NORTHERN IRELAND AMBULANCE SERVICE TRUST

TRUST BOARD - THURSDAY 9 MAY 2024 AT 10.30AM

Conference Room

NIAS North Division HQ

121-125 Antrim Road

Ballymena

BT42 2HD

Agenda

1 Welcome, Apologies & Declarations of Conflict of Interest

For Information

2 Minutes of the previous meeting held on 28 March 2024

For Approval

3 Matters Arising

For Noting

4 Chair's Update

For Noting

5 Chief Executive's Update

For Noting

6 Orla's Story

For Noting

7 HSC Trusts Equality and Disability Action Plans

For Approval

8 Trust Performance Corporate Scorecard (April 2024)

For Noting

9 Finance Report (March 2024 - Month 12)

For Noting

9 - NIAS Finance Report TB Month12 2023-24.pdf ***Page 133***

10 Committee business:

- PFOD Cttee - minutes of meeting on 29 February 2024 & report of meeting on 18 April 2024

For Information

10 - 01 - People Cttee mins 290224 signed final.pdf ***Page 143***

10 - 02 - 180424 PFOD Cttee report final.pdf ***Page 161***

- Safety Cttee - minutes of meeting on 25 January 2024 & report of meetign on 25 April 2024

For Information

10 - 03 - Safety Cttee mins 250124 final.pdf ***Page 163***

10- 04 - 250424 Safety Cttee report final.pdf ***Page 190***

11 Date & venue of next meeting: Thursday 27 June 2024 at 2.30pm in the Boardroom, NIAS HQ

For Information

12 Any Other Business

Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of NIAS Trust Board held on Thursday 28 March 2024 at 10am in the Boardroom, NIAS HQ, Knockbracken Healthcare Park, Saintfield Road, Belfast BT8 8SG

Present:	Mrs M Larmour	Chair
	Mr D Ashford	Non-Executive Director
	Mr P Corrigan	Non-Executive Director
	Mr J Dennison	Non-Executive Director
	Dr P Graham	Non-Executive Director
	Mr M Bloomfield	Chief Executive
	Mr P Nicholson	Director of Finance, Procurement, Fleet & Estates
	Dr N Ruddell	Medical Director
Apologies:	Mr P Quinn	Non-Executive Director
	Ms R Byrne	Director of Operations
	Ms L Charlton	Director of Quality, Safety & Improvement (QSI)
	Ms M Lemon	Director of Human Resources & Organisational Development (HR & OD)
In Attendance:	Ms M Paterson	Director of Planning, Performance & Corporate Services
	Mr N Sinclair	Chief Paramedic Officer
	Mrs C Mooney	Board Secretary
	Ms R Finn	Assistant Director QSI (obo Ms Charlton)
	Ms L Gardner	Assistant Director HR & OD (obo Ms Lemon)
	Mr M Cochrane	Assistant Director of Operations (obo Ms Byrne)

1 **Welcome, Apologies & Declarations of Conflict**

The Chair reminded those present that they should declare any conflicts of interest at the outset or as the meeting progressed.

The meeting was declared as quorate.

2 **Previous Minutes (TB28/03/2024/01)**

The minutes of the previous meeting held on 22 February 2024 were **APPROVED** on a proposal from Mr Corrigan. This proposal was seconded by Dr Graham.

3 **Matters Arising (TB28/03/20234/02)**

Members **NOTED** the Matters Arising.

Mr Bloomfield referred to the domiciliary care pilot and advised, while NIAS would not be involved in this, it would see the benefits of the pilot if it improved patient flow.

Ms Paterson advised that she had attended the Getting It Right First Time (GIRFT) workshop on behalf of the Trust and had met with the Team prior to the workshop. She said that the GIRFT Team had been encouraged that the recommendations had already been incorporated within the extant workplan. Ms Paterson explained that Mr Sinclair had presented on behalf of NIAS along with colleagues from the other Trusts on the actions being taken. She said it was intended that the Trusts' plans would be submitted to the Strategic Planning and Performance Group (SPPG) by 3 June to allow performance management arrangements to be put in place. Ms Paterson said that, between now and then, work would be undertaken to ensure all Trust plans dovetailed to ensure the most effective outcome from the work.

Mr Sinclair commented that it had been a very positive meeting.

Ms Paterson advised that NIAS staff would be meeting with Regional Co-ordination Centre (RCC) affiliates to understand what mechanisms could be put in place to ensure the NIAS plan contributed effectively, understanding how reliant NIAS was on other Trusts in terms of influencing handover times.

Responding to a question from Mr Corrigan as to how other Trust plans differed from the NIAS plan, Ms Paterson explained that other Trusts were clearly focussing on the patient pathway upon admission and discharge with a recognition that more could be done around the social care aspects in the community. She acknowledged that this was outside the ability of NIAS to influence. Ms Paterson said there had been agreement in the meeting that much more focussed attention was needed on the 'here and now' in an effort to reduce some of the pressures further on in the pathway. She added that this approach had been welcomed by colleagues in unscheduled care and EDs.

Ms Paterson said she had found the unscheduled workshop useful as she had become aware of other work being taken forward, for example, the review of domiciliary care capacity, and other work which could be shared as examples of good practice. She added that there was a recognition that it would take time to see the benefits of this work.

Mr Bloomfield acknowledged he had not attended the workshop but said it was his understanding that SPPG colleagues had emphasised the priority the Minister attached to the issue of ambulance handovers.

Mr Sinclair agreed and said there was a very strong indication from the SPPG of the challenges presented to NIAS as a result of delayed handovers.

The Chair suggested it would be helpful for the Board to have sight of the plan.

Ms Paterson advised that she had met with Dr Graham, ARAC Chair, to agree a revised approach in respect of the Risk Register. She added that this would be progressed over the next 6-8 weeks with a view to providing an update at the May ARAC.

Dr Graham said he hoped the work would result in the Risk Register becoming more readable and exact. He explained that the system currently used by the Trust produced all the history associated with the risk and he hoped that it would be possible only to have current issues associated with the risk. Dr Graham said that the work would also consider how risks might be devolved to Directorate level as a significant proportion appeared operational in nature.

Mr Dennison asked whether consideration would be given to inherent or residual risk as part of the review.

Responding, Dr Graham confirmed that this had been incorporated into the review.

The Chair said it would be helpful to organise a session in the near future with members which could consider the risk appetite of the Board.

Ms Paterson agreed that this would be useful in terms of ensuring the Board had a clear understanding of the risk appetite moving forward, particularly in the context of future financial challenges.

Dr Graham explained that he intended the work would refine the risk register with the aim of identifying key areas as Board risks as opposed to operational risks.

4 **Chair's Update**

The Chair noted that she would soon be a year in post and said it remained her intention to continue to engage with staff throughout the organisation. She advised that she had met with staff from the Quality, Safety and Improvement Directorate and said this had provided her with a useful insight into ongoing work.

The Chair said she had had an opportunity to visit the Air Ambulance NI (AANI) and Helicopter Emergency Medical Service (HEMS) in mid-March and had gained an insight into how the charity maintains services with clinical support provided from NIAS. The Chair said she had also taken the opportunity at that time to meet with staff from the Hazardous Area Response Team (HART). She noted the commitment and enthusiasm shown by staff she had met throughout the organisation since her appointment as Trust Chair.

The Chair alluded to the visit made by Board members earlier that morning to the Integrated Clinical Hub at Site 5 and said she remained optimistic when she heard of the commitment from senior management in terms of increasing resources.

Continuing her report, the Chair advised that she had met separately with the Trust's Independent Advisers, Mr Sowney and Ms Mitchell, to discuss the review of their respective roles and agree a way forward. The Chair acknowledged that, with a full Non-Executive Director complement now in place, both Mr Sowney and Ms Mitchell were aware that the need for Independent Advisers would reduce over time. She recognised, however, that there would be a transitional period and agreed to keep members apprised.

The Chair reported that she had met with Mr Colin Coffey, Chair of the Public Health Agency (PHA) and added that Mr Coffey would also assume the role of Chair of Public Sector Chairs' Forum on 1 April. The Chair said that the PHA was an important stakeholder and partner in relation to population health as well as looking at work around prevention and early intervention.

The Chair said that, since the previous Board meeting, the Permanent Secretary had convened a workshop with NI HSC leaders to discuss a new commissioning approach. She indicated that, while several priorities had been identified from the workshop, three priorities had been highlighted for future working, namely commissioning approach, performance/accountability and system narrative. The Chair advised that she had been asked to join the system narrative task and finish group and had asked for the group membership to include Mr Coffey and Ms Ruth Sutherland, Chair of the Patient and Client Council, to ensure the public were at the centre of what system narrative needed to reflect.

Continuing, the Chair noted that the group had now met on a few occasions to look at what the key messages would be with a view to providing feedback to the main group convened by the Permanent Secretary. The Chair commented that the system narrative group had identified several further issues for consideration and the Permanent Secretary had asked the group to consolidate its position and provide feedback to the main group.

The Chair reported that the Equality Commission had celebrated its 25th anniversary through a number of equality and leadership events. She advised that she had attended a 'Women in NI' conference held during the same week as international women's day. She acknowledged the amount of work undertaken in the Trust to mark international women's day through telling the stories

of female leaders and encouraging other females in the workplace and recognising their contribution.

The Chair said that she would be meeting with Ms Lemon to be briefed on the work ongoing within the Trust in relation to equality and diversity, and would be keen to ensure there was a culture of encouragement in the organisation. She said she would keep members updated.

The Chair reported that she had recently joined a Teams call on gender parity and Boardroom diversity in the NHS and the HSC. She said she would welcome feedback from members on the report which had been circulated by Mrs Mooney.

The Chair advised that she had also attended the annual Leadership and Governance Conference organised by the Public Sector Chairs' Forum and the Chief Executives' Forum and said learning had been identified re shaping the future.

In her absence, the Chair congratulated Ms Charlton on completing the Transformational Leaders course and said she had been delighted to attend the graduation.

The Chair alluded to her attendance at the HSC Chairs' meeting with the Minister and said the meeting had received an update on the work around system narrative which in the future has potential to be used by the Minister when discussing the need for the public to have greater responsibility for their own health, understand the transformation required in the HSC and the associated challenges. For example, the potential for patients to have to travel to receive specialist services. The Chair noted that the Minister referred to the GIRFT report in discussions and said she had taken the opportunity to highlight NIAS' concern that so many challenges facing NIAS were dependent on outside influences.

Mr Corrigan enquired whether there was an Equality and Diversity Forum Group/Committee within the Trust.

Mr Bloomfield explained that there was a Women's Forum but acknowledged that it had not met for some time. He explained that the lead within the HR & OD Directorate for Equality and Diversity was currently on a career break and said that the changes within the Directorate would allow Ms Lemon to progress this area of work.

The Chair commented that, since her appointment as Trust Chair, she had noticed a consistent theme whereby male language is used unconsciously and acknowledged that this was not done in any way to cause offence and be exclusionary. She encouraged those around the Board table to take every opportunity to encourage learning and inclusivity. The Chair stressed the need for cultural reform and transition in the Trust and ensuring the use of inclusive terminology and language was an important step.

Ms Gardner explained that the Trust intended to commence work early in the new financial year in relation to reducing misogyny within ambulance services and improving sexual safety. She added that much of this work would be related to the promotion of raising concerns in a safe space.

Mr Corrigan commented that he was scheduled to meet with Ms Lemon on 8 April and planned to discuss wider Equality and Diversity issues with her.

Mr Bloomfield acknowledged that other ambulance services were also progressing work in relation to reducing misogyny and improving sexual safety and it was a priority for NIAS to progress this. He agreed with the Chair that, in some instances, there were generational issues at the core and said he was encouraged that the new cadre of individuals coming into the organisation were more reflective of the communities we live in.

The Chair stressed that the focus should not only be on gender but also on ensuring an inclusive workplace.

Ms Gardner commented that the work around reducing misogyny and improving sexual safety would be progressed in a phased approach and would lead to cultural reform.

The Chair's update was **NOTED** by members.

5 Chief Executive's Update

Mr Bloomfield reminded colleagues that he had had to leave the February Board meeting early to attend the Health Committee with other Trust Chief Executives. He explained that the opening presentation had provided him with the opportunity to highlight the

challenges faced by NIAS, in particular the ongoing issue of handover delays which continued to show a deteriorating position despite a focus on this over the last year. Mr Bloomfield said he had also highlighted the related increases in response times and the associated risks to patients as well as taking the opportunity to highlight the contribution the Trust can make to the wider transformation agenda.

Continuing, Mr Bloomfield commented that, in the subsequent Q&A session, and given the current focus on the financial position and pressures across the HSC, he welcomed the interest shown by Committee members in the ambulance service. He said it was clear that Committee members had a clear understanding of the role played by NIAS and of the services the Trust provided and were involved in. For example, the Community First Responder Scheme and the Trust's work with the NI Fire and Rescue Service (NIFRS) and St John Ambulance. Mr Bloomfield said he was asked about the workforce challenges, including the new paramedic students due to graduate from the Ulster University later this year and about those individuals who wished to return from GB to NI and had been unable to secure posts. He said that he had been able to clarify that, unlike most other Trusts, NIAS did not have a workforce supply issue and indeed had a waiting list of individuals wishing the join the Trust. Mr Bloomfield noted that other questions included the challenges posed by increased response times; SAI process; use of Independent Ambulance Services to support the Trust and the appropriateness of that; solutions to the handover issue, both long- and short-term; potential to cohort patients within an ED setting. Mr Bloomfield said that overall he had been encouraged by the level of interest shown by Committee members.

Mr Bloomfield reported that he had attended an event organised by the Royal College of Emergency Medicine and added that the Minister and the health spokespeople of the various political parties had also been present. He said that the focus was very much on pressures within EDs and the challenges faced by emergency physicians. Mr Bloomfield said he was again encouraged by the fact that there had been several references to the impact that these pressures were having on ambulance services. He was of the view that constantly raising the issue of delayed handovers and the associated risks over the last several years had raised awareness of the impact.

Mr Bloomfield noted that, in his speech, the Minister had also referred to the impact of delayed handovers on ambulance services and had indicated that he was pleased to be able to invest funding in the ambulance services to recruit new paramedics.

Continuing his report, Mr Bloomfield said that members would be aware of the RCC which had been established in December 2023 to help the overall system manage flow and equalise pressures across the system. He added that the RCC had also brought a constructive challenge function to all Trusts and worked with them in a service improvement role. Mr Bloomfield advised that Trust Chief Executives had now agreed to extend the RCC for a further six months to allow time to demonstrate its impact. He indicated that an independent stocktake would be carried out to identify any initial learning and what had worked well. Mr Bloomfield said that Chief Executives had now met with the individual undertaking the stocktake and arrangements were being made for meetings with wider Trust teams.

Mr Bloomfield commended those involved in the Trust's social media coverage of international women's day and believed that the interviews with female leaders within the service served as positive encouragement to other females considering joining NIAS. He indicated his agreement with the Chair that there should be a constant focus on the importance of women's role in the service and not just on international women's day.

Turning to workforce, Mr Bloomfield explained that, while the Trust awaited the additional 48 newly qualified paramedics who would become available later in the summer, the Trust continued to recruit and train new staff within its existing funded establishment in order to maintain staffing levels.

Mr Bloomfield said that he had met with the latest group of staff who had just completed their 20-week Associate Ambulance Practitioner (AAP) course and who would be commencing operational duties at the start of April. Mr Bloomfield said that he also looked forward to welcoming paramedics and AAPs to the Trust who were joining from other ambulance services.

Concluding his report, Mr Bloomfield referred to the NIAS Leadership Conference which would take place on 26 April 2024 in

the Dunsilly Hotel, Antrim and said he hoped Non-Executive Directors would be able to attend.

The Chair thanked Mr Bloomfield for his update which was **NOTED** by the Board.

6 **NIAS Partnership Agreement (TB23/03/2024/03)**

The Chair said she would welcome the opportunity to take members' views in relation to the Partnership Agreement. She explained that the Partnership Agreement set out the arrangements whereby the DoH and the Trust were engaging in a new partnership approach.

Ms Paterson advised that the Trust Directors of Planning had met to reconcile views on how to influence the narrative and had undertaken a benchmarking exercise to ensure a level of consistency. She said that, at that time, it had been felt that the document represented a positive baseline position from which to progress. Ms Paterson added that several Trusts had already signed their Agreement which had then been published on the DoH website.

Mr Ashford noted that the Management Statement Financial Memorandum (MSFM) would be replaced by the Partnership Agreement and sought clarification on whether the MSFM would be phased out. He said that he would expect to see more detail as to what appropriate autonomy might look like.

Mr Bloomfield said that much of the narrative around roles and responsibilities had reflected the content of the MSFM. However, he acknowledged that there was already a closer working relationship between the Trust and the DoH which represented a closer partnership approach than previously.

Dr Graham commented that he had had some previous experience of Partnership Agreements through his involvement with the education sector which was now working to its second Partnership Agreement and said he had found very little difference in moving from the previous arrangement.

Mr Corrigan said that, in his experience in other sectors, there were more mature Partnership Agreements. However, he acknowledged

that the Agreement represented a starting position. Mr Corrigan was of the view that, while the Agreement provided the narrative around the approach, the actions beyond that would be of more importance and he welcomed Mr Bloomfield's view that working relationships had already changed.

The Chair said she did not disagree with any of the comments made. However, she highlighted that the Trust would be held to account through the Partnership Agreement. She acknowledged that several of her queries may relate to wording in legislation and therefore could not be amended, however, she highlighted several concerns and sought clarification around these, namely:

- Page 9 - reference to 'Health and Social Services Trusts';
- Page 10 – reference to 'Chairman';
- Page 13 – Board Operating Framework – does this mean Standing Orders?;
- Page 13 – code of practice for Board members;
- Page 15, para 9.2 – 'shared understanding of the risks that may impact on each other, and these are reflected in respective Risk Registers';
- Page 17, para 11.3 – 'NIAS will work in collaboration and partnership with the Department to prepare corporate and business plans…'

The Chair questioned whether, in relation to risks, there was a shared understanding of the risks given that NIAS had consistently been highlighting the risks associated with delayed handovers and no progress had been made. She said it was her understanding that the DoH had not shared the DoH Risk Register with Trusts.

The Chair said she was not aware of a commissioning plan.

Mr Bloomfield reminded the meeting that there had not been a commissioning plan for several years and said discussions were ongoing in relation to designing a new commissioning process.

Dr Graham suggested that the corporate plan would be largely influenced by the Minister's priorities.

Mr Dennison asked if that the Chair was proposing the Trust would not yet sign off the Agreement until further clarification was

received. He was of the view that the Agreement did not represent a Partnership Agreement as such but was a behaviour agreement.

The Chair asked members if they would be comfortable signing the Agreement in the absence of this further clarification. She explained that she had requested the Agreement come before the Board for noting rather than for approval until she was assured members would be happy to sign it off.

Mr Bloomfield accepted that there could have been a greater level of partnership working in developing the Agreement, however he believed it represented a positive baseline position on which to move forward.

The Chair commented that it was clear members were not entirely comfortable with approving the Agreement in its current format. She said that, with members' approval, she would discuss the Agreement further with Mr Jakobsen and Mr Wilkinson and explain that members were supportive of engaging around the Agreement and ensuring the focus was on the document remaining live.

Mr Bloomfield suggested that clarification would be sought from the DoH on the points highlighted by the Chair with a view to ensuring an amended document was brought back to the Board for consideration.

Members agreed with this approach.

7 **Strategic Priorities 2024-25 (TB28/03/2024/04)**

Ms Paterson alluded to discussion at the Strategic Planning Away Day attended by members on 15 February and explained that she had met with the Trust's Assistant Directors' Forum to outline to them the outworkings of the Day with a view to determining the key priorities for the Trust.

Ms Finn acknowledged the discussion which had taken place at the Forum and said the general feeling had been that the strategic outcomes could be delivered. She said that discussion had touched upon governance and assurance and the importance of ensuring the work could be embedded into 'business as usual'. Ms Finn said that there had been specific reference to the language to be used and the importance of referencing quality as well as efficiency. She

said that the Forum had committed to developing the enablers into a deliverable plan for the 2024-25 year.

Ms Gardner said that the Forum welcomed the presentation and discussion with Ms Paterson and highlighted the importance of working collectively on delivery. She commented on the number of significant enablers and the importance of prioritising these to achieve the objectives.

Mr Cochrane welcomed the focus on specific workstreams and issues which were deliverable rather than have a broad range of outcomes.

Dr Graham commented that the development of the Trust's Corporate Plan provided an opportunity for 'entrepreneurship' and 'thinking outside the box' as well as adopting the approach that everything should be considered.

Mr Bloomfield highlighted a number of key priorities that the Trust had to continue to progress, for example, maintaining progress on attendance management; progression of clinical model; maximising efficiency from PCS; operational performance, including to address rest periods, late finishes and EPRR.

Mr Corrigan believed that having a renewed focus would be helpful and also examining what areas of work could cease in order to create the necessary capacity as not everything could be designated as a priority.

Mr Bloomfield agreed with Mr Corrigan's comments and was of the view that the Corporate Plan for 2024-25 would have fewer priorities. However, he said it would be important to strike a balance and ensure that the work not prioritised within the Corporate Plan would continue to be progressed through Director's and team objectives. Mr Bloomfield referred to discussion at the recent Remuneration Committee when the Committee was of the view that Directors' objectives for the 2024-25 year should be 'smarter' and not reflect work to be progressed as part of business as usual.

Dr Graham agreed with this approach and suggested that consideration of core duties and tasks would help narrow the vision with a view to determining what actually needed to be progressed.

Mr Ashford commended the paper and asked how the Trust intended to capture the clinical education programme.

Responding, Ms Paterson clarified that this would be progressed within the Clinical Strategy. She acknowledged that the paper would be further refined in terms of sequencing and having clarity around the interconnections and interdependencies of the various areas of work being progressed.

The Chair was of the view that this was achievable when there was a small number of strategic priorities included within the annual project plan. She commended the paper and believed it was a useful way of capturing the discussion.

Mr Ashford asked whether the Trust could contribute to public health campaigns.

Ms Paterson advised that she had met with the NI Statistics and Research Agency (NISRA) and had discussed how they might be able to use NIAS data from a population health perspective.

Dr Ruddell clarified that the references to clinical insights and the use of care records related to patient pathways and transformation. He stressed the need to ensure that the Trust delivered the highest quality of clinical care to those patients being treated. He acknowledged that data driven insights would be very useful and suggested that it would now be timely for the Trust to revert to a position of measuring how patients were treated in terms of ensuring the Trust was delivering the right care. Dr Ruddell believed that, as a clinical organisation, this point should be explicit within the strategy.

Ms Paterson advised that Mr McKenna, Assistant Director of Operations, had stressed this point at the Forum meeting and the importance of ensuring that REACH would assist in clinical audit and supervision.

Mr Sinclair agreed and pointed out that this had been incorporated into the Clinical Strategy. He agreed that REACH would assist in this regard as well as research and development around the longer term outcome data. Mr Sinclair highlighted the importance of developing an evidence base for practice.

The Chair asked whether there was an opportunity to seek views from colleagues on the ground. She acknowledged the involvement of Assistant Directors but suggested it would be important to get feedback from operational staff as to whether they felt the objectives were appropriate to the challenges they face.

Ms Paterson noted the need to consult with staff and patients and agreed that it would be helpful to discuss how this might be progressed with the Assistant Directors' Forum.

Ms Finn referred to the Partner Voice and suggested that this might offer an opportunity for consultation with service users.

The Chair suggested that there would be an increased chance of success if there was ownership.

Dr Graham agreed and said that this would also feed into the Trust's Engagement Strategy.

Referring to next steps, Ms Paterson explained that the way forward would be to get feedback from the Assistant Directors' Forum which would progress the Plan. She said that, running in parallel, there would be a focus on wording and outcomes as well as considering timeframes.

The Chair thanked all involved and said it would be important to progress the Plan as quickly as possible but at the same time ensure there was clarification and ownership around the strategic objectives.

Members **NOTED** the draft strategic priorities for 2024-25.

8 **Trust Performance Corporate Scorecard (March 2024) (TB28/03/2024/05)**

Mr Corrigan alluded to the response times and the reference to the impact of ASOS. He said it was his understanding that all Trade Unions (TUs) had accepted the pay deal and asked when the Trust expected ASOS to cease. He noted that, while ASOS would be lifted, the issues around handover delays, response times, end of shift protocol would remain.

Mr Bloomfield agreed with Mr Corrigan's comments. He reminded the meeting that, before the start of ASOS, the Trust had commenced work to hold calls towards the end of shift specifically with a view to prioritising the release of crews at EDs. He explained that, as part of ASOS, TUs had advised their members not to respond to any calls other than Cat 1 calls in the last hour of shift. Mr Bloomfield said that the Trust had been having ongoing discussions with TU colleagues to agree the best way to collectively provide the safest service to patients and meet the needs of staff.

Dr Ruddell explained that, prior to ASOS, the Trust had developed a process for end of shift whereby it had examined primarily Cat 2 calls associated with high risk conditions and identified those calls which were likely to be time critical/time sensitive, for example heart attacks, stroke. He advised that, other than the high-risk calls, calls were held to allow for the prioritisation of releasing those crews waiting long periods of time at EDs. However, Dr Ruddell commented that ASOS meant that crews were not responding to any calls, other than Cat 1 calls, in the last hour of shift and therefore patients at risk of heart attack and stroke were not receiving a timely response. Dr Ruddell stressed that the Trust could not revert to a position where crews were waiting outside EDs for up to 5-6 hours past the end of their shift. He highlighted the need to focus on staff welfare as well as ensuring staff cover was not lost due to compensatory rest.

Ms Gardner reminded the meeting that the issue of pay was only one element of the dispute and said that safe staffing had also been highlighted as an issue. She updated the meeting on the respective TU position in relation to ASOS and said that UNISON ASOS was due to cease on 1 April while NIPSA action would continue until the end of June. The position with regard to GMB and Unite was not yet clear.

In response to a question from Mr Corrigan, Ms Gardner advised that approximately 60% of Trust staff belonged to UNISON.

Mr Dennison noted that discussion on ASOS had featured quite significantly at the last PFOD Committee and said that Ms Lemon had undertaken to provide an update on TU partnership working at the April meeting.

Ms Finn commented on the position with regard to Patient Care Services and reminded the meeting that the Trust was now reverting to scheduling more patients on transport. She explained that, during the pandemic, it was usual for a single patient to be transported.

Mr Corrigan noted that two thirds of patients were not arriving to appointments on time and asked if patients were still being seen.

Responding, Ms Finn confirmed that Trusts were flexible in relation to outpatient appointments and most patients arriving late were still seen. However, she said, there was less flexibility in relation to scheduled day procedures, for example dialysis patients were receiving less time on dialysis if they arrived late for their appointment. Ms Finn stressed that this was not acceptable and advised that a bespoke piece of work was being undertaken to ensure patients were not impacted. She noted that improvement would be seen moving forward and was not referenced in the Performance Report before the Board.

Mr Ashford commended the report and believed it provided a good summary of the Trust's current performance.

Ms Gardner said she was pleased to report a reduction in the in-month absence figure for the third consecutive month. She noted the progress being made in terms of the focus being on the management of long-term bases. She indicated that, at the end of December, 230 staff were on long-term sick. This had reduced in January to 201 and to 174 in February. Ms Gardner noted that there had been a slight increase in short-term absence and said the Trust had adopted the same approach in terms of looking at those staff who had had a number of episodes of absence within a 12-month period.

Ms Gardner drew members' attention to the benchmarking information within the report and noted that the February information was not yet available. She advised that the Delivering Value Programme Board would be meeting in the coming days to undertake the end of year review and determine the structures to be put in place for the 2024-25 year in terms of the management of absence.

The Chair acknowledged the effort that had gone into the management of absence and believed that the increased focus at local level had helped to ensure NIAS was able to compare its position with that of other Trusts. She was of the view that the continued effort and scrutiny would continue to be necessary and said she had found the benchmarking information helpful.

Mr Cochrane highlighted the team effort and advised that, on the same day last year, the Trust had 181 staff absent from work and this year there had been 131 staff absent from work. He acknowledged that a number of staff had been waiting on external factors, for example AW33 outcomes.

The Chair believed that the continued effort across Directorate and working in partnership was key.

Mr Corrigan said he was aware anecdotally that staff were conscious of the increased focus on absence.

The Chair agreed that this was important and believed that this would then start to shift culture.

Mr Bloomfield commented that, from April to December, the Trust's monthly absence was over 14% and he welcomed the reduction in January to 13.6% and 12% in February. He said he hoped the figure at the end of March would also be positive and added that he would like to be in a position to see the cumulative figure starting to reduce.

The Chair highlighted the continuing deterioration in handovers from Quarter one 8.8%; Quarter two 12% and Quarter three 19% and noted that this was an 'uncomfortable position' from a governance and accountability perspective. The Chair reassured members that she and Mr Bloomfield took every opportunity to highlight the continuing deterioration.

Members **NOTED** the Report.

9 **Finance Report (Month 10) (TB28/03/2024/06)**

Mr Nicholson reported on progress against the three statutory financial performance targets, namely manage within allocated Revenue Resource Limit (RRL); manage within allocated Capital

Resource Limit (CRL) and prompt payment target of 95% of suppliers within 30 days.

He said that members would be aware the Trust had been forecasting a breakeven position. However, he noted that expenditure levels could vary significantly between months and at different times of the year. Mr Nicholson advised that the levels of expenditure had been lower than previous years and less than the forecasted amounts as part of the forecast breakeven position. He said the Trust was working through the detail and to quantify the impact of this downturn and the potential impact on breakeven.

Mr Nicholson drew the Board's attention to page 5 of the report which set out expenditure against Voluntary and Private Ambulance Services (VAS/PAS), including taxis. He advised that expenditure remained significant in both areas and varied between months and years across each area of expenditure.

Mr Nicholson said that the Board had heard of the work of the Delivering Value Programme and was of the view that the many reductions evident in the current year were as a direct result of the work being done by staff to manage expenditure in these areas. He said he would welcome early engagement with these fora as the Trust moved into the 2024-25 financial year.

Mr Nicholson referred to the Capital Resource Limit (CRL) and advised that, at the time of writing the report, the position remained the same as reported to the February Trust Board, ie expenditure at the end of January 2024 was £1.550 million against a total allocation of £6.381 million. He said a significant amount of work remained to be done around expenditure ahead of the end of the year end. Mr Nicholson explained that expenditure had traditionally been profiled towards the year end due to a number of factors, including business case approval, availability of funds, procurement timescales.

Continuing, Mr Nicholson said he had previously briefed Trust Board on the business case for replacement defibrillators and the submission made to the DoH. He said he was pleased to report that, earlier that morning, the Trust had received the final formal approval to the business case to replace defibrillators across the service.

Responding to a question from the Chair on whether this could be achieved in-year, Mr Nicholson explained that he would provide further detail in the In Committee session.

Mr Nicholson drew members' attention to the Trust's performance against the prompt payment compliance and reminded the meeting that the target was to pay 95% of invoices within 30 calendar days of receipt of a valid invoice as well as a further regional target to pay 70% of invoices within 10 working days (14 calendar days). He advised that, while performance against these targets had slightly reduced in January, it had not reduced the Trust's cumulative performance figure. Mr Nicholson said he remained confident that the cumulative performance would be achieved.

The Chair thanked Mr Nicholson for the Finance Report (January – Month 10) which was **NOTED** by the Board.

10 **Committee Business:**

- **PFOD Committee – minutes of meeting on 6 December 2023 & report of meeting on 29 February 2024;**
- **(TB28/03/2024/07)**

Members **NOTED** the Committee minutes and report of the meeting.

Mr Dennison gave a brief synopsis of discussions at the February PFOD Committee and welcomed the in-month reduction in absence figures and acknowledged that it would be some time before a cumulative reduction was evident.

Mr Corrigan said that he had joined the Committee for the first time at its February meeting and commented that the agenda appeared to be heavily focussed on HR elements.

The Chair thanked Mr Corrigan for his observation and reminded the meeting that members had agreed to consider reviewing the operation of the Trust Committees in the summer.

13 **Date of Next Meeting**

The next NIAS Trust Board will be held on Thursday 9 May 2024 at 10am in the Boardroom, NIAS HQ.

14 **Any Other Business**

(i) Cyber Security Awareness Training

Ms Paterson reminded members that they would receive a presentation on cyber security awareness in the In Committee meeting.

(ii) Application of the Trust Board Seal

Mr Nicholson explained that the Trust Standing Orders required that 'documents should only be sealed following a resolution by the Trust Board. In exceptional circumstances, a document shall be sealed in advance of a resolution by the Trust Board and retrospective resolution sought at the following Trust Board meeting.'

He acknowledged the urgency associated with affixing the Board Seal to the following documents:

- Lease renewal in respect of Carrickfergus Ambulance station for a further five years;
- New contract for Computer Aided Dispatch (CAD) system (seven years);
- Lease renewal in respect of Ballynahinch Ambulance station for a further five years.

The Board **APPROVED** the affixing of the Trust Board Seal to these documents.

THIS BEING ALL THE BUSINESS, THE CHAIR CLOSED THE PUBLIC MEETING AT 1.05PM.

SIGNED: _____

DATE: _____

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD – 28 MARCH 2024

		INDIVIDUAL ACTIONING	UPDATE
	PUBLIC		
1	GIRFT implementation plan – copy to be shared with Board members	MP	Emailed on 30/4/24
2	Update on review of Risk Register to be provided to May ARAC meeting	MP	Listed for May ARAC
3	Organise session with members to consider the Board's risk appetite (aligned with Board meeting)	MP	Ongoing
4	Independent Advisers – keep Board updated	Chair	Update e-mailed on 16/4/24
5	Equality & diversity – keep members updated on work ongoing in Trust	Chair	Ongoing

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	09 May 2024
Title of paper:	HSC Trusts Equality and Disability Action Plans and Consultation Report
Brief summary:	These papers apply to six HSC Trusts who have worked together to develop, consult on and publish updated Equality and Disability Action Plans in line with legal responsibilities. The Trusts will work together on the implementation of these and ongoing engagement of stakeholders in this regard.
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forum:	SMT
Prepared and presented by: **Date:**	Michelle Lemon, Director of HR& OD 02 May 2024

Health and Social Care

Equality and Disability Action Plans 2024-2029

Consultation Feedback Report

January 2024

Contents page

Acknowledgement

We would like to extend our sincere appreciation to everyone who participated in our listening events and to all those who provided considered responses during the public consultation. Your valuable contributions have helped to shape our plans.

In the true spirit of partnership working, co-production and co-design we look forward to working with the Section 75 groups and disabled people in seeking to implement the measures in our plans.

Alternative Formats

If you require this information in a different format for example, a minority language, Easyread, large print, Braille or electronic formats please contact Consultation@nias.hscni.net

1 Introduction and background

The six Health and Social Care (HSC) Trusts have concluded their public consultation on their draft regional equality and disability action plans. These plans set out the actions we proposed to take forward collaboratively over the next five years.

This consultation ran for sixteen weeks and five days commencing on 5 June 2023 and closing on 30 September 2023. During the consultation period, consultees were invited to respond to the draft plans to ensure that the measures identified impact positively on the lives of service users, carers and staff.

Pre-engagement

The draft plans were shaped and developed with input from a range of stakeholders during three pre-consultation online listening events on 28th June,1st July and 25th October 2022, the latter facilitated by Disability Action. The purpose of these events was to engage with key stakeholders regarding development of our new 5-year Equality Action Plan (EAP) and Disability Action Plan (DAP). The feedback received helped to shape our plans. Our draft actions were also informed by our broader research and audit of inequalities.

Consultation Process

On 5 June 2023 we commenced a public consultation on the draft Equality Action Plan and draft Disability Action Plan. The consultation closed on 30 September 2023. We extended the length of the consultation given that summer holidays fell during the consultation period. The consultation was an opportunity for members of the public and interested parties to comment on the proposed content of the plans and to share ideas, knowledge or experiences to help inform and shape the final plans.

We used several different methods of engagement, detailed below, to encourage interested groups and individuals to provide feedback.

Requesting responses from individuals and representative organisations

To raise awareness of the consultation process we publicised the consultation documents through our regional consultation list, made up of 445 organisations and representative groups and in addition through local groups and organisations including service user and carer groups.

A letter was also sent to consultees reminding them of the closing date for consultation. Consultation documents were made available to the public on all the Trusts websites. We made all attempts to ensure the consultation was easy to understand. Plans were available in British and Irish Sign Language and easy read format and other formats on request.

An on-line proforma, hosted on Citizen Space, was available to complete. We are mindful that to engage through Citizen Space individuals need to have access to a suitable device, broadband, and knowledge to complete an online proforma. In recognition that some people may prefer to respond in a different way, we welcomed responses in other formats including hard copies of written or typed responses, sent in by post, or email, by means of face to face meetings and responses provided over the telephone.

Listening events

We held two consultation listening events on 25th and 26th of September 2023. The in person listening event on 25 September was held in a central geographic location and participation was enable through accessible facilities and communication support. Communication support was also available at the on-line listening event on 26 September.

Participants had the opportunity to view the draft plans and to provide feedback.

We would like to thank everyone who attending the listening events. It allowed us to hear some very memorable testimonies and to hear about local dimensions and lived experiences.

Feedback received

A total of 12 responses were received during the formal consultation period. These responses, along with feedback from listening events, have been collated into key themes relating to the EAP and to the DAP and are detailed below.

The Plans have been amended to reflect the feedback we have received.

Our Trust Boards have considered this report and the amended plans at their public meetings held throughout January/February 2024. On approval, this report and all amended plans are available on all Trust websites and all individuals and organisations we have engaged with and those listed on the consultation database have been notified.

Outcome of consultation and engagement

We received a total of 12 responses via Citizen Space and directly. In addition, the feedback received at the two engagement events held during the consultation period has been collated. Given the different forms of responses we have categorised the feedback we have received into key messages in relation to the EAP and the DAP.

These key messages are reflected in this report for our Trust Boards and for information purposes for interested stakeholders. Plans have been amended to reflect the feedback we have received.

On approval, this report and all amended plans will be available on all Trust websites and all individuals and organisations we have engaged with and those listed on the consultation database will be notified.

Working in Partnership

We are committed to working in partnership with service users and carers and representative organisations to realise our plans. Building on the good practice that already exists across health and social care we will adopt creative and innovative ways to maximise involvement in the challenging times ahead. We will continue to work with individuals, representative groups and our trade unions to make sure that our actions make a real difference both for our service users and for our staff. In the spirit of true partnership working we will continue to participate in the Joint Consultative Forum so that we, as HSC Trusts, continue to work closely with the Equality Commission for NI, the Community Relations Council and the Northern Ireland Human Rights Commission in taking forward our Plans.

The pre-election period restrictions caused a delay to the consultation process and as a result the timeframe for the Equality Action Plan and Disability Action Plan have been revised. Please note many actions within both Plans are in progress and updates will be provided in the Trusts 2023/2024 Annual Progress Report.

2 Consultation feedback

Given the different forms of responses (from listening events, Citizen Space survey, narrative responses) we have analysed and grouped the feedback received into emerging key messages relating to the EAP and to the DAP as detailed below. There is also a general comments section included for both the EAP and DAP where comments received did not align to any of the thematic areas of the plans.

Equality Action Plan (EAP)

The EAP has allocated actions to five main themes:

- Improving the data we use to support decision making
- Addressing barriers to accessing health and social care
- Supporting our staff
- Supporting informal/family carers
- Partnership working

Feedback received that relates to these themes is detailed below.

Section 1 Improving the data we use to support decision making

The introduction to this section acknowledges that "we need to improve the data we collect". During consultation specific feedback was given, with detailed examples, indicating where data collection could be improved.

In respect of the action to encourage staff to update their equality monitoring information, it was suggested that this data could be seen as sensitive information in Northern Ireland and that many staff members may wish to continue to opt out of providing their personal information. It was further noted that staff should not feel pressured to complete this data. There was concern that this could especially be an issue for minority groups of staff who felt they could be identified by their personal data. It was further noted that if data relating to the Section 75 categories is not being collected from employees, for example in relation to disability, dependent status, ethnicity or sexual orientation, then it will lessen the ability of Trusts to properly assess the impact of action measures/policies on the promotion of equality of opportunity.

Questions were raised in respect of data collection procedures in this area, particularly the uniformity of data collection across the Trusts, whether staff will be given training and dedicated time in respect of input of data, whether there is support available if required to help staff input data, whether staff will be assured of the value of providing equality data and also that data shared in this way will not lead to negative consequences for individual staff members.

It was noted that ENCOMPASS will introduce a digital integrated care record to Northern Ireland and that collaborative working will be applied

to ensure that the system monitors ethnicity, first language and communication support needs of patients and service users. It was suggested that involvement and consultation with all Section 75 groups in the design stage of this system is viewed as very important. It was recommended that the needs of transgender people are also incorporated into the system on a need to know basis, depending on the type of service being accessed by the patient. It was suggested that patients could be given access to add information about communication and mobility needs directly to their record. The counter view was also expressed that patients should not feel compelled to provide data that is not necessary for their care if they prefer not to.

In respect of the action relating to the Integrated Care System and the proposed partnership working to develop population health plans, the view was expressed that an ability by health and social care organisations and third sector charity organisations to access this information could help support their service delivery direction and activities.

The view was expressed that the new Integrated Care System (ICS), and the process to develop of population health plans, needs to ensure that population data is accurate and the data used should be made public. It was stated that, if population plans are open and transparent, inequalities can be assessed and ironed out at design stage.

It was felt that more information is required about how the development of population health plans will work in practice. It was suggested that data/information should be independently collated by professional statisticians and standardised, official data should be used.

There was also a suggestion that the data used in an Equality Impact Assessments should be accurate and gathered from an independent source such as NISRA.

Trust response

It is important to provide assurance that all equality information gathered is anonymised and all information is stored/retained in compliance with data protection requirements.

While staff will always have the option of not completing this data it is important to clarify that through the collection and analysis of this data

allows the Trust to put in positive programmes to support staff within the nine equality categories.

Each Trust gathers information about staff equality categories using a standardised information system and the Trusts are holding clinics to support staff to input their data.

The Trusts will continue to work with Encompass to ensure that Section 75 groups are involved in its implementation. Encompass has established an Encompass Engagement Council and each Trust will continue ongoing communication with Encompass to ensure the needs of Section 75 groups is reflective in its ongoing implementation.

Encompass allows patients to input information about their communication needs in the 'My Care' portal.

The Trusts are committed to gathering accurate, timely information when carrying out Section 75 screenings, Equality Impact Assessments and Rural Needs Impact Assessments. The Trusts are also committed to being open and honest about the source of information and to making all information available to the public.

Section 2 Addressing barriers to accessing health and social care

The Trusts duty to promote good relations between persons of different religious belief, political opinion or racial group was endorsed. It was suggested that this means that no one will be forced to adapt an opinion if they do not believe in it, for example, people who believe in "scientific biology".

Positive feedback was received in respect of the Good Relations poster acting as a visible sign that diverse representation and participation matters. The action, that includes a commitment to extend the Belfast Trust Good Relations Strategy to all Trusts, was positively received.

There was a query around the consistency of approach across Trusts to providing accessibility information on Trust services to disabled people prior to their hospital appointment. Examples given include disabled staff and visitors requiring information on building access, room access, toilet/changing places access and treatments available. It was

suggested that this could be provided online or provided in leaflet format prior to their appointment. An example was given of a woman with an acquired brain injury, who is also a wheelchair user, attending for a smear test, and whether they can identify in advance such as access into the room and a height adjustable bed.

A further example of difficulty in accessing service was given relating to a service user with sight loss who stated that they continuously receive letters advising of appointments, a method that is not able to be utilised by them.

A specific example was also given in respect of a person with a brain injury attending an appointment and whether additional time will be taken to facilitate their sensory or information processing needs. A suggestion was made that they (if desired) have a card similar to the interpreting card, so that their unique needs can be considered when booking an appointment. There was a query raised over the use of appointment reminders and whether support can be provided during the appointment by family members.

It was suggested that consideration should be given to making disability guidance and interpreter information easier for staff to access.

The regional communication support service for people who are Deaf or Hard of Hearing was seen as a positive development, which should be fully resourced and available in all regions. The Trust Wi-Fi service was noted a problematic for some users and a particular issue for sign language interpreters.

There was a query if NIAS is aware of the remote sign language interpreting app which can provide sign language communication support in the case of an emergency.

There was concern whether disabled people can be fairly included in social prescribing, perceived to be an up and coming treatment approach. It was suggested that Trusts consider having Disability Access Champions or provide specific information on access needs within the online communications hub.

Regarding the two new models of more accessible facemasks for people who have hearing loss, are Deaf/deaf and lip read it was commented

that, when information about these is rolled out, it must be fully accessible to the deaf community.

Additional comments relate to the use of the Loop system for communication with deaf/Deaf and hard of hearing service users and ensuring staff are aware and know how to operate it. It was also suggested that Trusts should examine where loop systems need to be installed in Trust premises.

A comment, in relation to adequate resourcing to meet demand and availability, was made in relation to the Northern Ireland Health and Social Care Interpreting Service (NIHSCIS). It was suggested that the interpreter card should be digitized in Encompass and the patient portal to ensure that it will then not be lost or forgotten by the patient and always available. A further suggestion related to the creation of visual displays around facilities promoting interpreting services.

A query was raised in respect of capacity of interpretation services at points of high demand, which may adversely impact availability at the patient's appointment time, and how this is addressed particularly for on-site/ treatment support rather than by phone.

It was noted that it was positive that neuro-diverse conditions such as ASD, ADHD, Dyslexia, Dyspraxia, ADD etc. have been recognised and included in the proposed Equality Action Plan. Respondents asked to be involved in delivery of this action. It was proposed that more information could be provided regarding specific services, interventions, treatments and reasonable adjustments available. It was also highlighted that neurodiversity is an issue for staff as well as patients and, on a practical level, providing quiet places or sensory rooms for both staff and patients to take time out if needed would be useful. This is particularly important in busy departments such as emergency departments. A further comment suggested the inclusion of service users with physical brain damage, as well as developmental, in the neuro divergence actions and outcomes.

Other comments include the inclusion of more suggestions of reasonable adjustments for individuals with a neurodiversity such as alternative ways to engage with services, make appointments etc. other than the standardised telephone call. Email, letters, texting or live chat options should be included. In addition, it was stated that, individuals with neuro-diverse conditions can struggle to process, understand, retain

and recall information, especially when overwhelmed or overstimulated, so reasonable adjustments could include allowing audio recording of appointments or providing written information on the topics discussed during the appointments. Appointments should be made during the least busy/more quiet times of day, minimised light and/or sound where possible, quiet spaces offered outside of the general waiting rooms, advance warning of appointments to give the individual time to prepare and reminder email/text/letters if possible. Test results could be sent via post instead of making the individual telephone to receive them.

Further detail was requested on the Rural Needs Toolkit for Health and Social Care and what it covers. It was further noted that disabled people, as well as older people, have challenges around transport and that the use of the Rural Needs Toolkit for Health and Social Care and completing Rural Needs Impact Assessments to include this group, as well as older people, could be beneficial. The issue of suitable and timely transport for older and disabled people for appointments was raised in the context of centralisation of services across Trusts.

Questions were raised in respect of the adoption of the rainbow symbol by Health Trusts. The feedback related to the perceived promotion of gay rights specifically and not the promotion of others related to, for example, different religious views such as the Muslim faith or the Jewish faith. Additional queries were raised in respect of the rainbow badge specifically whether, if staff choose not to wear a badge, it is not a sign of not being inclusive and should not be interpreted as such. It was further asserted that the Trust should be advertised as an inclusive environment where everyone is treated equally rather than catering to specific staff groups which could encourage segregation.

The development of a resource for staff comprising guidance produced by professional bodies in terms of best practice for inclusion for people who are LGBT+, was welcomed.

Trust response

The Trusts are committed to working with disabled people to ensure accessible information is provided prior to appointments in healthcare settings.

The Trusts are aware of the continued use of appointment letters that are inaccessible for disabled people. It is anticipated that the ongoing

implementation of Encompass will result in recording of service user communication requirements and communication about appointments.

The Trusts are 'Just A Minute' (JAM) card friendly. The JAM Card supports autistic people and those with communication difficulties. The JAM Card logo and materials are displayed in public areas where all visitors entering the building will see it.

The Trusts will work with their IT Departments to explore how all information about interpreting is available on Trust devices including access to Remote Sign Language Interpreting Services and can download the SignVideo app on their devices.

The Trusts will ensure that up to date guidance on disability equality information and interpreter information on their intranet systems and that this is continually communicated across the organisation.

The Trusts will ensure that any social prescribing programmes include access for disabled people. It is important to note the development of new Trust services are subject to Section 75 screening and through the screening process access issues will be identified.

Sign Language Interactions offer a full range of communication supports including, face to face interpreting, remote sign language interpreting, relay interpreters, interpreters for deafblind people, lip speakers, electronic notetakers and speech to text reporting.

A number of HSC Trusts are working with AccessAble to produce on-line access guides to trust facilities particularly for disabled people when planning and navigating their journey.

The Trusts will work with the Northern Ireland Health and Social Care Regional Interpreting Service (NHHSCIS) to ensure access to interpreting support is promoted. The Trust will continue to provide staff training on the best use of interpreting services whether face to face or interpreting.

The Trust is committed to working in partnership with service users and carers to take forward Action 14 and 15.

The Rural Needs Toolkit is available on all Trust websites.

We will amend Action 17 to include disabled people.

All reform of services will be subject to Section 75 Screening, Equality Impact Assessment if appropriate and Rural Needs Impact Assessment where transport and travel times will be examined in detail and appropriate mitigation identified.

In terms of promotion of other faiths or minorities, the Trusts are all adopting a consistent good relations strategy to promote good relations amongst people of different religious belief, racial group or political opinion. We have co-produced a regionally consistent HSC good relations statement, which is printed on posters across our facilities. This is our visible commitment that we will actively challenge racism and sectarianism, we will treat each other fairly with respect and dignity and we will make sure our spaces are shared, welcoming and safe. All Trusts seek to promote an inclusive environment for all and seek to address inequalities.

Section 3 Supporting Our Staff

The ethnically diverse staff network was welcomed as a positive development. However it was queried whether there are, or should be, equivalent staff networks available in respect of other Section 75 categories such as age, disability, gender or sexual orientation.

Respondents welcomed flexible working, work life balance and special leave policies as positive developments. It was also suggested that flexible working for staff could reduce the need for locum staff and associated issues.

Comments were made in respect of the implementation and widespread use of the disability passport for staff. It was queried whether there will be an equivalent disability passport for service users with communication needs.

The commitment within the EAP to review employability schemes to enhance employment opportunities for marginalised Section 75 groups was viewed as positive. It was suggested that the Trusts, as major employers in Northern Ireland, could set more specific and ambitious

objectives and targets in terms of employability initiatives, to improve outcomes in terms of placements and paid employment opportunities for under-represented people, in different job groups and grades, in the Section 75 groups. It was further suggested that this work could be aligned to the work undertaken by Trusts as part of their Fair Employment Annual Monitoring and 3 year Article 55 Reviews.

It was suggested that the wording in relation to health inequalities for staff could be changed from the wording "gender" to "sex" for clarity although it was further acknowledged that the "gender pay gap" has been traditionally used to refer to the gap in pay between men and women. It was stated that there may be preparatory work that the Trusts could undertake in advance of the planned "Gender Pay Regulations" becoming law with reference made to the Equality Commission guidance on undertaking an equal pay audit.

The view was also expressed that, in recent times a new meaning for the word "'gender" has emerged (as in "gender expression" or "gender identity"), and in this context it is important to recognise that the protected characteristic in Section 75 of the NI Act 1998 is "men and women generally" and that "gender reassignment" is addressed under separate regulations.

It was suggested that inclusive pregnancy status is a current issue for staff groups who work with any form of radiation, including those who are transgender, and a Trust or region wide approach or guidance on this would be welcome.

Trust response

The regional HSC LGBTQ+ HSC Staff Forum work collaboratively and have been instrumental in delivering the HSC wide participation in the 2023 Belfast Pride Celebrations and disseminating the Rainbow Badge initiative.

As part of the April 2022 review of HSC terms and conditions of employment, each HSC Trustpromotes flexible working and that includes applicants and all Trust staff from day one of employment. We continue to promote this via HR training events and highlighting best practice across a range of services.

We are currently developing a reasonable adjustment plan/disability passport for staff with a disability. This document will record the reasonable adjustment(s) relating to a specific job role. This will improve communication and awareness, provide increased assurance for disabled staff and avoid any lack of continuity when there is a change of management. Each HSC Trust will implement this by end March 2024 and we will incorporate into our regional Attendance Management Policies.

Regional HSC Trusts will continue to consider employability schemes and continue to work collaboratively to increase recruitment opportunities for disabled people.

HSC Trust including Payroll Services are continuing to work collaboratively in readiness for the implementation of the planned "Gender Pay Regulations". We have included this work stream in our EQUIP working groups (the replacement of our current HSC wide HR, Payroll & Travel information system)

HSC NI is currently developing a new HR system that will eventually replace the existing HSC Jobs website. We acknowledge the challenges experienced by disabled applicants and work is underway to improve accessibility of the website. The HSC application process and the support that can be offered to applicants is currently under review. Our links to this support within the HSC Jobs website and landing page will have increased visibility for ease of reference for disabled applicants who require adjustments or support with their application.

We will work with disabled people to develop, review and benchmark our progress with regards the application process.

Reviews of policies including our "Family Packs" "Maternity Information Sessions" have included updating terminology and language to be more inclusive and reflective of equality, diversity and the wide range of parents and family networks.

Each of the HSC Trusts are committed to improving employment opportunities for disabled applicants and ensuring our disabled staff are supported, enabled and empowered to develop their careers within the HSC across a diverse range of roles and specialities.

Each HSC Trust has committed to review, update and implement our Disability Toolkit. This Toolkit will be utilised by managers and colleagues to provide guidance, support and signposting to disability services both within each HSC organisation and or externally.

We are currently reviewing our Making a Difference Equality Training which is mandatory for all HSC staff and managers. This training includes disability awareness and we aim to implement this across the HSC Trusts by end March 2024. In addition, we will review and update disability awareness training by March 2024.

We will continue to work in partnership with our respective Disability Steering Groups within HSC Trusts comprising representatives from disability groups and Trade Union colleagues to ensure our focus and commitment to disability awareness, improved opportunities for disabled staff and improving accessibility and equality in employment generally for disabled people. Our groups will meet regularly, report to our respective Trust Boards and update the Equality Commission as part of our annual progress reports.

We will continue to work with disability organisations to coordinate unpaid work experience placements for disabled people to increase their experience and improve their ability to apply for posts via open recruitment.

Each HSC Trust will continue to collate data and statistics in accordance with GDPR and Equality Commission guidance and best practice regarding our workforce and our staff with disabilities. We will utilise this data in our Section 75 screening and planning processes to ensure we meet the diverse needs of our staff.

We will continue to raise awareness among our workforce of the importance of staff declaring this information and we will ensure psychological safety and a culture of equality, diversity and inclusion to encourage staff sharing information regarding their disability.

Section 4 Supporting informal/family carers

Actions relating to Carer's Rights Day received positive feedback as did the action related to facilitating conversations between carers and their named worker.

Queries were raised in respect of the carer supports including whether these are available regionally and held at times that support carers who are employed. It was suggested they should be both face-to-face and virtual to facilitate attendance and the methods of promotion or marketing of the supports was queried.

There was a concern about accessing a carer assessment if the carer does not have a social worker.

It was queried if carer supports are open to all family members who provide care or whether there any similar groups that support the whole family including parents, carers and siblings. It was asked, where no support is available, whether the Trust signposts to supportive/charitable organisations.

Clarification was sought whether unpaid carers can be assured they will have the same considerations as paid workers i.e., those who received direct payments or Self Directed Support (SDS) to support their family member.

It was stated that increased provision of 'respite' for carers needs to be considered.

Trust response

The Carer Co-ordinator's in each Trust area work collaboratively and with carers to develop an accessible carer support and short break programme. Young carers receive addition support through contracts with the voluntary sector. The Trusts work with a number of community and voluntary organisations to ensure carers can be signposted to support in their local area.

General comments

There was agreement that a unified approach is key and the documents are clear and well written and mostly adhere to a focus on S75 groups. There was also feedback that the documents need to contain to a lot less jargon and be written in Plain English.

It was highlighted that procurement functions and equality screening processes should be included in the EAP.

There was a view that actions in the Plan should be prioritised and be clear and outcome focussed.

Positive feedback was also received in relation to the provision of the EAP in different languages.

Comments were received in respect of the Audit of Inequalities, the document used to inform the draft EAP and for future equality screening and assessments. Suggestions were given in respect of useful publications that could be considered.

Concerns were raised about the omission of the issue of deprivation in the EAP, specifically in relation to NISRA deprivation data.

It was suggested that the EAP could include a section on how health authorities ensure meaningful public consultation and that this should be standardised across Trusts. It was also suggested that equality impact assessments and rural needs impact assessments need to be part of the process.

It was suggested that the EAP could include a new section introducing and explaining the procedures in place if Trusts fails to comply equality and rural needs legislation.

Support of gender critical (GC) people and women's groups that are protecting women's sex based rights was suggested as an additional area to consider in the EAP.

Suggestions include outlining on the plan the process for greater communication and stakeholder involvement to deliver the actions on the agreed final EAP.

In respect of past achievements detailed in the introduction to the EAP, respondents welcomed and valued the guide covering Making Communication Accessible for All but noted that all staff should have some way of being made aware of this including the suggestion of provision of training by webinar delivery.

A query was raised about the recording of completion of equality training at staff level so that if a difficulty arises relating to Equality, Good Relations, Disability and Human Rights, signposting can be made back to a staff member's training.

Positive comments were also made in relation to the co-production of the Disability Equality Training Resource and Disability Toolkit, the inclusion of "experts by experience" and the decision to engage with external experts and representative organisations to provide specialist training for employees.

It was suggested the prevention measure should be included in the EAP to raise awareness and change attitudes towards diversity.

It was suggested that the EAP should include actions that address the known health inequalities among ethnically diverse communities and ensure equality of access to facilities and services.

In addition it was suggested staff should be trained in anti-racism and cultural awareness.

Trust response

The Trusts are commitment to creating accessible versions of the Plans.

The Trusts are committed to mainstreaming Section 75 and Rural Needs in the procurement of services, in accordance with statutory responsibilities.

It is important to note that if the Trusts are consulting on any change to service, Section 75 screening or Equality Impact Assessment and Rural Needs Impact Assessments when required are completed and available as part of the consultation process.

It is important to note the actions in the Equality Action Plan were developed from our Audit of Inequalities and engagement with key stakeholders. The Trust has now reflected on the feedback received during the consultation and has combined some of the actions and prioritised the timescales accordingly.

As public authorities the Trusts will ensure that their consultation are meaningful and comply with legally binding principles.

The Trusts' Equality Schemes detail the process to follow if there is a concern of non-compliance.

The Trusts equality training, which includes the promotion of equality of opportunity for people from different racial groups is mandatory for all health and social care staff. Completion of mandatory training is recorded and compliance is monitored.

The Trust is committed to working with representative organisations to ensure that they use the appropriate language in the documentation.

Disability Action Plan

Disability Action Plan (DAP)

Feedback received has been aligned to the themes in our draft Plan in Section 1 and Section 2 below. Any further feedback has been allocated to the 'general comments' section.

Section 1 Actions to promote positive attitudes towards people with a disability

The measure to produce and place a Directory of Advocacy and Support Services on each Trust website was positively received by a number of respondents. Queries were raised in respect of the process of review and maintenance of this resource to ensure information is current and complete. There was a concern that there may be differences in service provision between Trust areas and questions were raised about what would be recommended in the event of this. The remit of the directory was queried with a specific question as to whether the support available will be expanded to include the voluntary sector and specifically opportunities for community rehabilitation. Promotion and marketing of this resource was considered very important with the use of social media, posters and leaflets where possible.

It was acknowledged that there is a need for visibility of disabled people and the promotion of disability equality with comments made that 1 in 4 people have a disability, including Trust staff as well as the people the Trust supports.

It was noted that a DAP action commits the Trusts to using pictures of 'Disabled people using services', it was suggested to also use pictures of 'employees' with disabilities, this would help to improve attitudes towards disabled people, i.e. to highlight that disabled people are not only in receipt of services, they are employees and potential employees also.

There was support for the proposal to have a calendar of events to promote visibility of disabled people. There was a suggestion that there should be consultation and working together to identify and agree what events should be highlighted by the Trust.

There was support for the promotion of the social model of disability. It was noted that this should include the use of images which re-enforce a positive image of disabled people accessing Trust services, as well as

the increased promotion of disability related events on Trust websites, local intranets and social media. It was further noted that consideration should be given to the use of images of people with hidden disabilities.

Positive feedback was received in relation to the rollout of the regional sign language service. It was noted that it is the responsibility of staff to book the interpreter for an appointment and to keep the service user informed. It was also noted that there needs to be better access to Sign Video within hospitals using computers and phones accessing the Trust Wi-Fi.

It was suggested that alternative methods of communication could be considered, for example text or email to confirm appointments and this could be incorporated as a commitment into the action plan.

There was support for the inclusion of the action promoting early involvement of, and co-production with, disabled persons in developments and changes to services.

It was recommended that working with voluntary groups should be mandatory. It was further noted that disability steering groups already include members from the community and voluntary sector.

It was also noted that involvement activity needs to be accessible for people who work out of hours and are deaf. It was further noted that these groups are often held during working hours and therefore not allowing the younger disabled people to have their say in how improvements could be made.

It was suggested that maximising and publicising opportunities for involvement could be achieve by the appointment of a disability champion in each Trust. This person either has lived experience themselves or liaises regularly with a diverse group of disabled people or disabled people's organisations. In this way, the richness of disability is always reflected and represented.

There was support for the commitment to ensure that the DAP is accessible, available in Plain English and in easy read versions. There was also support for the proactive dissemination of the Disability Action Plan to key stakeholders and all those who support disabled people.

There was support for the actions relating to help and support for staff who have a disability to remain in the workplace and feel adequately supported at all times to enable them to carry out their role at work. There was feedback reminding that not every staff member will wish to disclose all disabilities to numerous people and departments.

Suggestions made, specifically for deaf/Deaf staff, include the creation of a peer group or forum to provide support and advice to each other and the provision of information to newly appointed deaf/Deaf staff in respect of access to work, ensuring managers are aware of this.

There was strong and positive support for the need for all health and social care staff to be trained on disability duties and disability equality and that such training could positively contribute to working well with disabled people. Positive feedback was received in respect of the action detailing the intention to review the training Guide and associated toolkits. It was further stated that disability training requires to include all nuances of disability and be seen as a training event that promotes the value of disabled people, their skills, and the unique perspectives they can bring to Trust working. Department specific training was suggested for consideration, for example, how to accommodate for the person with the disability within the department by demonstrating through a walk-through or mock scenario. A further example given in relation to encouraging others actions is that the action plan for example will extend disability awareness training requirement to private domiciliary care workers.

Training being facilitated by disabled people was seen as ideal. It was recommended that the Oliver McGowan training should be included as an action within the plan.

It was queried whether diverse lived experiences covering physical, intellectual and hidden disabilities were currently represented within the Disability Equality Training Resource as well as experiences from disabled people themselves and their families/carers.

A further question was raised in respect of "experts by experience" and whether they were involved throughout in the design, implementation and review of disability training. It was suggested that regular liaison or co-production of processes alongside third sector stakeholders would be ideal.

A suggestion was made that staff undertake deaf awareness training to ensure easier communication with deaf/Deaf service users.

There was positive feedback received from a number of respondents in support of the development of employability schemes and enhancement of increased employment opportunities. It was cautioned that, in the implementation of these actions, there needs to be an assurance that disabled people will not feel disadvantaged by disclosing their disability or when using employability schemes. It was suggested that inclusion of disabled people within recruitment of staff or to employment schemes could help ensure this process is fair and inclusive. Recruitment processes should also take reasonable adjustments required into account. It was also noted that, from personal experience, it is perceived that there needs to be more support after employment secured to ensure reasonable adjustments are put in place and access to work is provided. Feedback by other participants noted that their experience of work experience was excellent as was the facilitation of communication by use of sign language.

Trust Response

The Trusts will consider the feedback received when developing the directory of advocacy and support services and will ensure the directory is coproduced with representative organisations.

The Trusts will ensure that disabled employees are represented in images to contribute to positive attitudes. We are currently reviewing the development of a regional HSC staff network for disabled staff.

The Trusts will coproduce the calendar of events to promote the visibility of disabled people and ensure social model of disability is promoted.

The Trusts are currently working to promote access to SignVideo within hospitals using Trust devices and Trust Wi-Fi. The Trust will amend the actions to reflect this.

The Trusts will continue to coproduce all disability equality training resources including deaf awareness training.

Trusts are currently scoping the adoption of the Oliver McGowan training.

The Disability Equality Training resource has been coproduced and includes the range of disabilities referred to above.

Each of the HSC Trusts are committed to improving employment opportunities for disabled applicants and ensuring our disabled staff are supported, enabled and empowered to develop their careers within the HSC across a diverse range of roles and specialities.

We will continue to work with disability organisations to coordinate unpaid work experience placements for disabled people to increase their experience and improve their ability to apply for posts via open recruitment.

Section 2 Actions to encourage participation by disabled people in public life

It was suggested that disability legislation in Northern Ireland is very complex and not accessible. It was further commented that provision of documents in other languages should be considered a vital part of accessibility along with plain English and easy read. It was suggested that there could be an element of co-production and involvement in the creation of easy read versions.

In respect of the need to improve visibility and awareness of jobs for anyone who is disabled there was a query raised in relation to the mechanism to ensuring that disability organisations are made aware of available jobs in HSC organisations.

The inclusion of disabled people working in partnership during the planning and design stage for new buildings was viewed as positive. Mapping of existing facilities and a review of estates was suggested as a good starting point. Additional outcomes were suggested that, in respect of improving accessibility to services for disabled people consideration be given to the installation of Changing Places toilets in all hospitals in Northern Ireland, particularly for out-patient departments along with increasing the number of accessible toilets in Trust buildings. It was also noted that there could also be greater availability of disabled parking spaces particularly in Children's at Royal Victoria Hospital.

Further comments included the need to ensure all work areas are accessible for people with disabilities, including wheelchair users, implementation of this may include increased use of auto-door openers for fire doors in office spaces.

The new information system, ENCOMPASS, was viewed as a positive development by a number of respondents. Feedback indicated that this system should ideally include the ability for service users to add information relating to mobility and communication support needs, cover all Section 75 groups including multiple identities and have a form of red flag alert for those with disabilities. It was also suggested that disabled people could work in partnership to help develop elements of the system and that a sign language representative should be part of the design group for this system. Staff training on the final system was highlighted as being very important. The requirement to equality screen implementation of the system was highlighted.

Disability placement schemes in partnership with the community sector were viewed as a positive development by a number of respondents validating and recognising the value of a diverse workforce and a proactive approach to improving access to health and social care employment for those who face health inequalities. Comments were made highlighting the recently introduced Disability Positive Accreditation Scheme which recognises local employers who put their commitment to employment of disabled people into practice. Elements to consider include job descriptions, reasonable adjustments, the ring fencing of posts for people with particular disabilities and employability in general including impact upon benefits. It was suggested that, given the status of the Trusts as major employers within Northern Ireland, there could be outcome focused disability employability targets included in the DAP.

Trust Response

The Trusts' final Disability Action Plan will be available in Easy Read and people with a learning disability will be involved with the development of the easy read versions.

Each Trust will scope availability of Changing Places and new facilities will be added as appropriate in accordance with legislation.

The Trusts will ensure compliance with Disability Discrimination Act in relation to work areas for disabled staff who require reasonable adjustments.

A carers action has now been included in the Trusts' Equality Action Plan and this includes young carers.

AccessAble will improve navigation to Trust facilities.

Trusts' will include scoping Disability Positive Accreditation Scheme in Action 31.

General comments

The inclusion of progress and outcomes from previous DAPs was highlighted as being useful to include in the new DAP i.e. outline any key learning points going forward from the 2018-2023.

There was a view that actions in the Plan should be prioritised and be clear and outcome focussed.

It was also noted that the DAP for 2024-2029 was developed on a regional basis, a good way of pooling resources, expertise and learning. It was suggested that consideration should also be given as to whether there is a need for any local action measures relating to specific Trust issues or areas of development.

It was noted that descriptor language used in the draft DAP moves between "people with a disability" and "disabled people". While acknowledging the importance of personal choice, it was suggested that a clarifying statement at the beginning of the plan in relation to language could be helpful to include and to guide the reader.

It was noted that the current DAP extends its current remit, in draft form, beyond the two disability duties and that it may be appropriate to concentrate on the disability duties alone.

A question was raised as to whether the United Nation Convention on the Rights of Persons with Disabilities (UNCRPD) guide for staff could be acknowledged and incorporated throughout the plan as it was asserted that considering this as a starting point is often invaluable.

A comment was made that all information shared at consultation events should be fully accessible to the deaf community and that adequate communication support should be provided.

Feedback received related to the large deficits in social care support and the impact on a disabled person's welling and quality of life. It was suggested that these need to be acknowledged within this plan citing long waiting lists to access social worker support and also to access carers as examples. Suggestions were made for an action to ensure female service users with disabilities to be provided with intimate care by females only.

It was suggested that cross departmental working should be increased within Trusts to reflect the fact that disability spans all nine Section 75 categories. It was also suggested that a central point of contact within each Trust would help with signposting to services.

Trusts were cautioned to be mindful that not all people have access to smart phones and that documents should be accessible to all.

Trust Response

The new DAP now includes a summary of progress from 2018-2023 DAP.

The Trusts have amended the DAP to describe the language used throughout.

The Trusts have amended DAP to incorporate UNCRPD guide for staff.

The Trusts are committed to working with disabled people to ensure accessibility to hospitals and Trust services.

The Trusts are committed to working in partnership with disabled people to ensure all communication is accessible.

The Trusts acknowledge the current challenges within health and social care. It is important to note that the DAP actions are reflective of the relevant legislation and the Plan cannot address the challenges the system is currently under.

Monitoring and review

We commit to keeping our plans as living documents which may be added to or amended over their lifespan of the next 5 years, as more information becomes available or priorities change.

Progress in implementing the measures contained in all the Plans will be reported on via annual Section 75 Progress Reports to Trust Boards and the Equality Commission. Copies of the progress reports will be made available on the Trusts websites.

Contact details of Equality Teams in your area:

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Equality Action Plan 2024-2029

HSC Health and Social Care

Contents

This document is available in alternative formats and language on request including:

- Large font
- Braille
- Main minority ethnic languages
- DAISY
- Easy-read
- Electronic version.

Please see contact details of the relevant Equality Team in each Trust on Page 36.

Welcome

Welcome to our new Equality Action Plan. This Plan sets out the actions the Health and Social Care Trusts will take forward collaboratively over the next five years.

There are six Health and Social Care (HSC) Trusts in Northern Ireland. Five of whom provide integrated health and social care services. These are as follows:

- **Belfast HSC Trust,**
- **Northern HSC Trust**
- **South Eastern HSC Trust**
- **Southern HSC Trust**
- **Western HSC Trust**

The sixth Trust is the Northern Ireland Ambulance Service, which is responsible for providing emergency, urgent and primary care services across all of Northern Ireland and safely transporting patients.

The six Trusts would like to take this opportunity to thank you for your contributions to our five year Equality Action Plan (2024-2029). This Equality Action Plan has been developed to tackle ongoing and emergent inequalities experienced by people protected by the nine Section 75 groups - that is people of different ages, religious beliefs, racial groups, political opinions, marital status, sexual orientations, men and women generally, people with and without disabilities, people with and without caring responsibilities.

How we developed this Plan

Actions and priorities in this Plan have been informed by an audit of inequalities. The purpose of the audit was to identify key areas of potential inequality. To ensure consistency of approach and equity across the region, the six Trusts have worked collaboratively to gather emerging themes in relation to key inequalities experienced by the nine equality categories. We have collated available research and data to identify emerging themes, which we shared at regional listening events in June and July 2022 with a range of stakeholders including service users, carers, staff and trade unions representatives. We have developed our Equality Action Plan based on our consideration of the research and the feedback from the listening events. We also issued our draft Equality Action Plan for formal consultation for sixteen weeks between June and September 2023. Our intention is to have actions that will make a real and meaningful difference to the lives of people in Northern Ireland by addressing the inequalities they experience or to better promote equality of opportunity. The audit of inequalities will also be a valuable resource for future equality screening and equality impact assessments.

Purpose of the Plan

We recognise that inequalities have regrettably worsened during the unprecedented global Covid-19 pandemic and the health and social care family, as a whole, is working continuously and collectively to try to address the long waiting lists, waiting times and workforce challenges. Many health inequalities will be addressed through the day-to-day provision of health and social care services – for example, higher prevalence of mental ill health will be directly addressed regionally through the implementation of the Mental Health Strategy and delivery of mental health services across the Trusts.

From the outset, it is important to acknowledge this Plan will not be able to tackle all of these systemic inequalities but will focus on those inequalities in health and social care experienced by those protected in law by the equality and good relations duties of Section 75 of the Northern Ireland Act 1998. We also know that some of the inequalities identified in our previous audit of inequalities are persistent, having not yet been fully addressed and will remain as ongoing themes, on which we will continue to focus. This Action Plan goes beyond our compliance with our respective Equality Schemes but is complementary to the Schemes and seeks to address inequalities relative to our functions. We have deliberately focussed our actions to achieve better accessibility in service provision and to promote inclusion and diversity for those who work in health and social care.

This five-year Plan is designed to be flexible, adaptable and responsive to changing needs, emerging inequalities and circumstances. We will also review the Plan alongside our corporate plans and any legislative changes.

Our achievements so far

The Trusts have worked collaboratively to address inequalities and to promote equality of opportunity and good relations. This collective approach has helped us achieve regional best practice and consistency and allowed us to combine our resources to maximise our efforts.

We provide updates in our annual progress reports to the Equality Commission and to our Executive Teams and Trust Boards to demonstrate the progress we have made (all of which are available on our respective websites).

For illustrative purposes, here are some details on just a few of our successful actions in our last Equality Action Plan.

Regional Health and Social Care Good Relations statement

During 2020, we engaged with service users, staff, trade unions and representatives from the community and voluntary sector, the Equality Commission for Northern Ireland, the Northern Ireland Human Rights Commission, and the Community Relations Council to develop a regional HSC good relations statement.

We have displayed this poster across Trust facilities in Northern Ireland with an unequivocal and consistent message in terms of our commitment to good relations and the behaviours we expect from our staff, service users and those with whom we engage.

Establishment of Ethnically Diverse Staff Networks

Staff networks have been established by and for staff of different ethnicities across Trusts to help promote equality, diversity and inclusion in all that we do and to focus on the needs of our ethnically diverse workforce to address and eradicate race discrimination and intolerance and to remove barriers our staff may experience.

Joint Equality, Good Relations and Human Rights Forum

The Trusts have established a joint forum in partnership with colleagues in the Equality Commission, Human Rights Commission and Community Relations Council to help facilitate joint working and the sharing of information and expertise to help address inequalities and uphold human rights and promote equality and good relations in health and social care.

Making Communication Accessible

The issue of communication has and continues to feature as a barrier – with a clear need for health and social care organisations to make improvements. The Trusts worked with disabled people and representative organisations to co-develop a guide for HSC staff on how to provide accessible communication for people with a disability.

It has been recognised as a useful and valuable resource in improving communication for people with a disability and their experience in health and social care.

Guidance for our Trust Board and Executive Team

The Trusts has developed a guidance for our Trust Board and Executive Team members as an aide memoire on the legislative requirements and matters to consider in their strategic decision-making.

Making a Difference Regional HSC Online Training

Equality, Good Relations, Disability and Human Rights training is mandatory for all staff and all professions and a regional HSC online resource entitled “Making a Difference” has been developed to enable staff and managers to complete this via e-learning. To complement this, the Trusts have also developed a guidance for staff to help them refresh their knowledge or reference as needed.

Supporting Carers

In recognition of the invaluable role that informal carers play, we held a workshop for health and social care staff who have caring responsibilities to identify how they can be supported to balance their caring responsibilities while continuing to work. The range of supports available to informal family carers includes a number of flexible working opportunities and a carer support programme.

Disability Equality Training Resource

Working in partnership with disabled people, we have co-produced a Disability Equality Training video. This video is delivered by people with a disability and is available for health and social care organisations and their partners to make sure disability people are treated with respect and dignity.

Disability Toolkit

The Disability Policy and Toolkit was co-developed by health and social care organisations and their respective trade union representatives and disability organisations. The one-stop Toolkit is available in easy-read format and a virtual, Page Tiger resource and provides a comprehensive overview of all issues related to disability for managers and staff.

Back to Agenda

Gender Identity and Expression Employment Policy

We have developed a policy that supports people who identify as transgender or non-binary in the workplace. We worked with individuals and with voluntary sector groups who represent people who identify as transgender or non-binary to inform our policy.

Value of co-design and collaborative working

None of this proactive work would have been possible without us engaging and working collectively with the people who face the inequality – those “experts by experience” ensure that these actions will make a real and meaningful difference. That is why we would encourage as many people as possible to take the time to review and influence the actions within our new draft Plan.

What is in our Plan?

The following tables outline our actions for the next five years. The Plan includes actions aimed at:

- Improving the data we use to support decision making
- Addressing barriers to accessing health and social care
- Supporting our staff
- Supporting informal/family carers

The principles of ***fairness, respect, dignity, equality and autonomy*** will inform our work.

How we will measure success of the actions in our Plan

This five year Plan is designed to be flexible and responsive to changing circumstances and needs and will evolve over its lifespan. The Plan illustrates how we will measure success through an outcomes-based approach. We will report annually on our progress against the Plan via our S75 Annual Progress Report to the Equality Commission for Northern Ireland (ECNI), which is submitted at the end of August each year and available on all of our websites or by contacting the Trusts' Equality Units.

www.belfasttrust.hscni.net
www.northerntrust.hscni.net
www.setrust.hscni.net
www.southerntrust.hscni.net
www.westerntrust.hscni.net
nias.hscni.net

Section 1 – Improving the data we use to support decision-making

We know that high quality data plays a role in improving services and decision-making. When Trusts have good population data, they can identify areas that have worse health outcomes and target health and care resources to reduce health inequalities. Feedback from consultees has indicated that we need to improve the data we collect in relation to health and social care inequalities. The following actions are aimed at improving the data we collect to ensure the effective discharge of our S75 equality duties.

The Trusts monitor staff across the 9 equality categories to ensure equality of opportunity. Staff input their own equality information on an online system but there are currently gaps in the data available.		
Actions	**Timescale**	**How we measure success**
1. We will take active measures to encourage staff to update their equality monitoring information as part of corporate welcome/staff induction and by developing a regional and local campaign to encourage staff to update their equality profile information.	April 2024 and onwards	• Regular awareness raising campaigns to encourage staff to update their equality data. • Development of regional and local campaigns with timescales for staff to update their equality profile. • Increase in percentage of staff completing their equality monitoring data.[1] • Promotional resources/Toolkits produced and disseminated to promote inclusion of all staff.

[1] n.b. Provision of equality monitoring data on our Information System is voluntary for HSC staff but staff are encouraged to complete and update.

Back to Agenda

		• Input into the EQUIP project to ensure the next HR IT system is fully appropriate and fit for operational purpose. Regional subgroups to support its development and implementation. • Benchmark where appropriate with examples of good practice.

ENCOMPASS is a new health and social care wide programme that will introduce a digital integrated care record to Northern Ireland.		
Actions	**Timescale**	**How we measure success**
2. We will work collaboratively to influence the ENCOMPASS programme to ensure that it monitors ethnicity, first language and communication support needs of patients and service users.	2024/25 and ongoing	• Ethnicity and communication support needs recorded on ENCOMPASS system. • Increased access to communication support in timely fashion. • Improved policy formulation, service delivery and population health data.

Under a new way of planning and commissioning services, the Integrated Care System (ICS) will bring together health and social care organisations, partners in voluntary and community sectors and local government, to develop population health plans to improve outcomes and wellbeing and reduce health inequalities.		
Actions	**Timescale**	**How we measure success**
3. We will work with partners to ensure the inclusion and analysis of Section 75 data in the development of population health plans.	April 2024 onwards	• Robust population health plans including Section 75 data. • Identification of health inequalities. • Targeted services that address identified health inequalities and improve health outcomes.

Section 2 – Addressing barriers to accessing health and social care

While much work has been done to date to promote equality of opportunity, it remains the case that there are a number of equality groups that continue to face particular and unique barriers. During the listening events and consultation period, we heard many suggestions on how to improve equality of access to health and social care services. The following actions have been developed in response to what we have heard and are aimed at providing welcoming, person-centred and accessible services for everyone.

Trusts have a duty to promote good relations between persons of different religious belief, political opinion or racial group. The regional Health and Social Care Good Relations Statement provides a consistent message in terms of our commitment to good relations. Belfast Health and Social Care Trust (BHSCT) has consulted on a co-produced Good Relations Strategy, which includes actions that will promote respect, equity and trust, and embrace diversity in all its forms.		
Actions	**Timescale**	**How will we measure success**
4. All Trusts will adopt the Good Relations Strategy and work collaboratively, with our partners, to take forward the actions and ensure consistency across Northern Ireland.	By April 2024	• Co-produced Good Relations Strategy. • Strategy adopted by all Trusts. • Consistent approach to promotion of good relations in HSC Trusts.

We know that there is a lot of information available on improving health and wellbeing but we need to make sure that the content is understood and accessible.		
Actions	**Timescale**	**How will we measure success**
5. We will co-develop a series of health and social care seminars with representative organisations, communities and individuals to support health and wellbeing and address inequalities.	2024 and biannually thereafter	• Improved inclusive health and well-being information, targeted at the effected communities. • Two regional seminars held each year. • Feedback and evaluation of seminars.
6. We will develop an online communication hub of best practice in accessibility for people with a disability.		• Online resource hub available for staff to improve communication. • Feedback and evaluation of communication hub. • Accessible communication training programme developed for front line staff.

During Covid-19, the increased use of facemasks caused communication difficulties for Deaf and hard of hearing people and people who lip-read. The regional Health and Social Care Communication Support Service for People who are d/Deaf, d/Deafblind and Hard of Hearing was established in 2023 to provide consistent and improved access to communication support when accessing health and social care services.		
Actions	**Timescale**	**How will we measure success**
7. We will ensure staff are aware of the Health and Social Care Communication Support Service for People who are d/Deaf, d/Deafblind and Hard of Hearing and the facemasks approved by Infection Prevention Control, that are more accessible for people who have hearing loss, are Deaf/deaf and lip-read.	2024 and ongoing	• Greater awareness of the regional HSC Communication Support Service for People who are d/Deaf, d/Deafblind and Hard of Hearing. • Greater awareness of the importance and availability of accessible facemasks. • Improved communication and patient experience. • Reduction in complaints. • Increase in compliments/positive feedback. • Proactive and targeted use of Care Opinion to promote better communication.

The Northern Ireland Health and Social Care Interpreting Service (NIHSCIS) provides professionally trained interpreters on a face to face basis and we also have a regional contract for telephone interpreting for people, whose first language is not English, when accessing Health and Social Care services across Northern Ireland. Feedback indicated that access to interpreting support remains a barrier for some when accessing services.		
Actions	**Timescale**	**How will we measure success**
8. We will develop an interpreting card for patients and service users to present when they are in health and social care facilities. The card will indicate that the service user needs an interpreter and include contact details for NIHSCIS.	2024	• Interpreting card for service users and patients to bring to their appointments to help support their communication needs. • Promotion of card in training sessions. • Increased staff awareness. • Reduction in complaints about lack of interpreting support.

Neurodiversity is a broad term, used to describe the many and varying ways in which human brains are wired. It encompasses the wide variety of ways humans think, learn, feel and process information. Neurodiversity can include Autism, ADHD, ADD, Dyslexia, Dyscalculia, Dyspraxia and Acquired Brain Injury. We acknowledge that staff, as well as patients and service users live with neurodiversity and there is a need to raise neurodiversity awareness in the workplace and in the provision of our services.		
Actions	**Timescale**	**How will we measure success**
9. We will draft and co-produce neurodiversity guidance and a podcast for our staff along with key stakeholders including experts by experience.	2024	• Production of an online signposting resource/service directory on neurodiversity services. • Increased awareness and information provision for staff in terms of people who are neurodiverse. • Improved user experience. • Improved awareness of information and services for people who are neurodiverse. • Dissemination and launch of guidance.

We know that rurality has an impact on equality of access to services, especially for older people, due to lack of accessible transport, times of appointments and the availability of rural and/or community transport. Covid-19 has resulted in a widening of the digital divide affecting older people who may not be familiar with technology.		
Actions	**Timescale**	**How will we measure success**
10. We will work with our partners to ensure that the needs of older and disabled people, who reside in rural communities are considered in service developments or by promoting and monitoring the use of the Rural Needs Toolkit for Health and Social Care and completing Rural Needs Impact Assessments to identify mitigations put in place.	April 2024	• Increased awareness of the needs of older people who live rurally. • Raised awareness of best practice in overcoming rural inequality and providing adequate and appropriate mitigations. • Increased number of rural needs impact assessments, where appropriate, which evidence consideration of rurality in service design and service change with reduction in any potential inequality for those living in rural areas.

We know that people may be reluctant to share their sexual orientation with health professionals and are unhappy having to disclose their sexual orientation repeatedly. We have also found that some people have had a negative experience when accessing health and social care services.		
Actions	**Timescale**	**How will we measure success**
11. We will implement the Rainbow Badge initiative whereby staff will complete online training to gain a HSC Rainbow Badge. This is a voluntary initiative. The badge will be used to symbolise an open, non-judgemental and inclusive place for people that identify as LGBT+.	April 2024 – March 2029	• Adoption of Rainbow Badge initiative in each Trust to ensure regional consistency. • Monitor the number of staff taking part in the initiative in each Trust. • Gather feedback from staff and service users.
12. We will develop a resource for staff comprising professional body guidance on best practice for inclusion for people who are LGBT+.	April 2025	• Consistent guidance available for health and social care professionals. • Increased staff understanding of improving access to services for LGBT+ service users. • Reduction in complaints and increase in compliments.

Section 3 – Supporting our staff

We know that our staff are our most valuable resource and the health and social care system in Northern Ireland is indebted to the work that they do every day and in particular, throughout the pandemic. We are committed to celebrating and embracing the diversity of our staff and to ensuring that they feel able to bring their authentic selves to work so that they feel valued and can continue to provide safe, effective and compassionate health and social care services.

We have one of the most ethnically diverse workforces in the public sector and it is vital that we continue to promote the inclusion and visibility of staff who come from ethnically diverse backgrounds.		
Actions	**Timescale**	**How will we measure success**
13. We will support the ongoing work of Trusts' ethnically diverse networks.		• Action plans developed to oversee Trusts' strategies on EDI for staff. • Policies reviewed, developed and recommended relating to EDI. • Internal and external EDI groups and networks better engaged. • Stronger links across the region between our Ethnically Diverse Staff Networks.

Back to Agenda

We know that there are still incidents of homophobia in the workplace towards staff who are LGBT+ and we know that there is an under-declaration amongst staff who record their sexual orientation as LGBT+.		
Actions	**Timescale**	**How will we measure success**
14. We will continue to work in partnership with LGBT+ representative organisations to ensure that training and awareness raising resources are consistent and up to date.		• Training developed to support staff to increase understanding of LGBTQ+ experiences. • Staff access to supporting resources. • Deeper understanding of the key issues LGBT+ people face to help create an inclusive environment for all. • Increased knowledge of appropriate language and policies that support inclusion.
15. We will promote the regional HSC LGBT+ network for staff across Trusts.		• Increased awareness and celebration of LGBT+ diversity. • Space provided for LGBT staff peer support. • Improve experience for LGBT+ staff by providing access to support. • Increased understanding of LGBT inclusion. • LGBT experiences more visible in the wider organisation.

Informal/family carers represent a significant proportion of the working population. A growing number of people working in health and social care are trying to balance their jobs and their caring responsibilities. The entitlement to carers' leave and flexible working arrangements are two of the main support measures that can help informal/family carers to keep a balance between their work lives and caring.		
Actions	**Timescale**	**How will we measure success**
16. We will improve awareness of options for flexible working, work-life balance, special leave policies to ensure they are accessible to all our staff.	Obtain baseline figures – April 23 Ongoing	• Establish baseline on uptake of flexible working and monitor year on year increase in staff accessing these opportunities. • Increased awareness of flexible working, work-life balance and special leave policies. • Monitoring reports produced twice a year on flexible working.

It is important that staff who have or acquire a disability are supported in the workplace by overcoming any potential barriers to achieving their full potential. Trusts are committed to creating a safe and welcoming environment for all staff.		
Actions	**Timescale**	**How will we measure success**
17. We will scope development of Staff Disability Forums and Networks to support regional consistency.	March 2024	• Effective implementation and widespread use of Disability Passport.
Actions	**Timescale**	**How will we measure success**
18. We will develop a plan in partnership with disabled staff members to ensure they are supported through the provision of reasonable adjustments where appropriate.		• Better support for disabled staff to return and remain in work. • Record available of what has been agreed previously to support disabled staff member if changing role. • Guidance available for managers on how to support disabled staff member.

Health and social care staff must have the foundation of effective policies and relevant training to support them to provide the most inclusive and compassionate health and social care services.		
Actions	**Timescale**	**How will we measure success**
19. We will develop a regional policy framework to ensure Equality, Diversity and Inclusion (EDI) policies are reviewed in line with governance requirements.	Throughout the lifespan of the Plan	• Equality, Diversity and Inclusion (EDI) policies reviewed. • Policies reflective of up to date advice and best practice from the Equality Commission and other legislative developments. • Regional consistency in EDI policies and equity for all staff across the Trusts.
20. We will update the regional HSC 'Making a Difference' e-learning programme further to review of best practice in E-learning and EDI training.		• Regional HSC Making a Difference e-learning programme updated. • Updated training incorporated best practice identified.

Actions	Timescale	How will we measure success
21. We will work to improve uptake of equality training, which is mandatory in all Trusts.		• Uptake of statutory mandatory equality training monitored. • Increased compliance levels with mandatory equality training. • Increased awareness of zero tolerance approach to racial harassment/ discrimination/ bullying and abuse at work.
22. We will identify an EDI Champion at a senior level in each Trust.		• Identified lead on EDI at senior level. • EDI Champion at senior level identified in each Trust.
23. We will work in partnership with trade unions to ensure that staff who experience domestic and sexual violence are supported in the workplace.		• Trust domestic and sexual violence workplace policy in place and support networks established. • Positive feedback from ongoing engagement from affected staff.

Personal stories can really resonate and be most impactful in terms of effectively communicating key messages. We recognise that collaborating with people with lived experience enhances the training we provide training and gives staff a different perspective, improving the services we provide.		
Actions	**Timescale**	**How will we measure success**
24. We will engage with external experts and representative organisations to provide specialist training for employees.	April 2024-March 2029	• Training sessions developed delivered and evaluated. • Marketing and promotional strategy to increase uptake of training across all Trusts.
25. We will develop a human rights based training programme and guidance for staff providing care people living in residential settings. We will share and actively promote these resources with Independent Sector colleagues, who provide this care.	March 2024 and ongoing	• Increased awareness and competence in providing person centred, person led care and what a human rights based approach. • Evaluation of training and associated resources.

We want to harness the talents of a diverse workforce and recognise that we need to take a proactive approach in improving access to health and social care employment for marginalised Section 75 groups.		
Actions	**Timescale**	**How will we measure success**
26. We will develop actions in line with legislative provision to improve access to those Section 75 groups, where there is a low representation in our workforce.		• Improved access to employment for marginalised Section 75 groups. • Equality data indicating better representation.
27. We will address specific health inequalities for staff, for example provide menopause information sessions and celebrate men's health week to promote inclusion and visibility of gender specific issues in the workforce.		• Raised awareness of gender specific health inequalities for staff. • Increased inclusion and visibility of gender specific issues. • Better support for staff with gender specific issues.
28. We will work collaboratively on the forthcoming gender pay gap legislation and determine appropriate methods of monitoring and reporting.	Dependant on enactment of legislation.	• Pay structure established that ensures fairness and equity in pay and reward arrangements.

Section 4 – Supporting informal/family carers

We know that many of us are likely to become a carer at some point in life and informal/family carers cover a great part of care needs, often called the 'invisible workforce'. Strengthening the voice and representation of informal carers is the first step to address the challenges facing informal carers. Informal care can be physically and mentally demanding, resulting in carers often feeling exhausted, lonely, and strained. Carer Co-ordinators in each Trust area work collaboratively with carers to develop an accessible carer support and short break programme. The Trusts also work with community and voluntary organisations to ensure carers can be signposted to support in their local area.

Recognition of the key role a carer plays is essential and we must provide support when the caring role is having a negative impact on the health and well-being of the informal/family carer. It is also important to make useful information and training easily accessible and available to informal carers.		
Actions	**Timescale**	**How will we measure success**
29. We will work collectively to ensure that carers across the region are aware that they can have access to a conversation with their named worker in relation to their caring role and needs The conversation is carer led and encourages both staff and carers to take time to discuss the caring role.	2023 Annually	• Increased uptake of carers assessments • Improved carer experience of the carer assessment process. • Carers across Northern Ireland receive the same information and know where to get help and support. • Increase in people who identify as carers, which will enable them to link into supports available. • Quarterly DoH monitoring.

Recognition of the key role a carer plays is essential and we must provide support when the caring role is having a negative impact on the health and well-being of the informal/family carer. It is also important to make useful information and training easily accessible and available to informal carers.		
Actions	**Timescale**	**How will we measure success**
30. We will hold an annual event on Carers Rights Day to highlight care and caring and help informal/family carers understand their rights and find out about support that may be available.		• Consistent, regional approach to Carers Rights Day.

Contact Details

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37

Disability Action Plan 2024-2029

HSC Health and Social Care







Contents

Page

Alternative Formats

This document is available in alternative formats including:

- Large font
- Braille
- Main minority ethnic languages
- DAISY
- Easy-read
- Electronic version.

Please see contact details of the relevant Equality Team in each Trust on Page 19.

Introduction

Welcome to our new Disability Action Plan. This Plan sets out the actions the Health and Social Care Trusts will take forward collaboratively over the next five years.

There are six Health and Social Care (HSC) Trusts in Northern Ireland. Five of which provide integrated health and social care services. These are as follows:

- **Belfast HSC Trust,**
- **Northern HSC Trust**
- **South Eastern HSC Trust**
- **Southern HSC Trust**
- **Western HSC Trust**

The sixth Trust, the Northern Ireland Ambulance Service, is responsible for providing emergency, urgent and primary care services across all of Northern Ireland and safely transporting patients.

The six Trusts would like to take this opportunity to thank you for your contributions to our Disability Action Plan.

Our Plan lays out the actions that we are proposing in response to our dual disability duties under Section 49A of the Disability Discrimination Act 1995 (as amended). We have developed this Plan to progress our two disability duties to promote positive attitudes and encourage full participation of disabled people in public life. Actions to

address inequalities experienced by disabled people are included in our regional five year Equality Action Plan, informed by our engagement with disabled people and representative organisations.

The actions in this Plan are based on feedback from disabled people and through our ongoing collective and local engagement. We remain committed to working in partnership with disabled people, their representative organisations and the community and voluntary sector and look forward to working collaboratively on our actions during the lifetime of this five-year Plan.

We will value and prioritise disabled people's voices and expertise to ensure the actions in this plan make a real and meaningful difference.

It is important to note that the Trusts are using the term 'disabled people' which recognises people as being disabled by barriers in society and not by any impairment or difference. We acknowledge that language can be a personal choice but hope that this clarification illustrates why we refer consistently to disabled people.
We will review it on an ongoing basis and provide annual reports against progress.

Our achievements so far

The Trusts have worked collaboratively to achieve regional best practice and consistency and allowed us to combine our resources to maximise our efforts.

We provide updates in our annual progress reports to the Equality Commission and to our Executive Teams and Trust Boards to demonstrate the progress we have made (all of which are available on our respective websites).

For illustrative purposes, below are a few of the successful actions in our last Disability Action Plan.

Making Communication Accessible

The issue of communication has and continues to feature as a barrier – with a clear need for health and social care organisations to make improvements. The Trusts worked with disabled people and representative organisations to co-develop a guide for HSC staff on how to provide accessible communication for people with a disability. It has been recognised as a useful and valuable resource in improving communication for people with a disability and their experience in health and social care.

Disability Equality Training Resource

Working in partnership with disabled people, we have co-produced a Disability Equality Training video. This video is delivered by people with a disability and is available for health and social care organisations and their partners to make sure disability people are treated with respect and dignity.

Disability Toolkit

The Disability Policy and Toolkit was co-developed by health and social care organisations and their respective trade union representatives and disability organisations. The one-stop Toolkit is available in easy-read format and a virtual, Page Tiger resource and provides a comprehensive overview of all issues related to disability for managers and staff.

Regional Communication Support Service

In January 2023, a regional procurement process was finalised for the provision a HSC Communication Support Service for People who are d/Deaf, d/Deafblind and Hard of Hearing, contracted directly by the Strategic Planning and Performance Group. By April 2023, a specialist Provider was secured to deliver a range of high quality, accessible, regionally consistent and sustainable communication supports for people who are d/Deaf, d/Deafblind, or Hard of Hearing across all HSC services. The design and development of the service reflects the RQIA Review of Sensory Support Services in 2011 and subsequent extensive research, public consultation and engagement with sign language users and interpreters. The establishment of a remote sign language interpreting service continues to ensure that our Deaf service users have access to a free online remote sign language interpreter 24/7 for health and social care appointments.

What is in our Disability Action Plan

The following tables outline what you have told us and the actions we will take over the next five years. This Plan is a live document. It is designed to be flexible and responsive to changing circumstances over the five-year period.

Our Plan will be reviewed on an on-going basis and we will report annually via our S75 Annual Progress Report to the ECNI, which is submitted at the end of August each year and available on all of our websites or by contacting the Equality Units.

Section 1 – Actions to promote positive attitudes towards disabled people

Disabled people have told us that negative attitudes are often the biggest and most common barrier they face and we believe as a large service provider and employer we have a vital role to play in shaping and modelling positive attitudes towards disabled people. Section 1 of this Plan focuses on promoting positive attitudes through an inclusive approach to the use of images and language, providing better training, guidance and support for our staff and ensuring our Disability Action Plan is easy to access.

What you told us	What we will do (*Actions*)	By when	How will we measure success
There is a need for greater visibility of disabled people.	1. We will continue to promote disability equality and the social model of disability through an inclusive approach to the use of images, which reinforce a positive towards disabled people and disabled staff members.	March 2028	• Increased visibility of disabled people and disabled staff, including those with hidden disability in Trust publications, use of social media and online presence. • Proactive promotion and communication of our coproduction with disabled people and disability-related events.
	2. We will mark and celebrate allocated disability – related days to raise awareness at a local and regional level.	March 2028	• Co-produced calendar of events organised and publicised annually. • Increased staff awareness of disability equality.

What you told us	What we will do (*Actions*)	By when	How will we measure success
That the disability legislation in Northern Ireland is very complex and there is a need to ensure our Disability Action Plan is accessible and easy to understand.	3. We will work with disabled people and representative groups to enhance the profile and accessibility of the regional Disability Action Plan to ensure that the legislation and disabled people's rights are easier to understand.	March 2025	• Increased awareness of the accessible Disability Action Plan internally and externally. • Disability Action Plan available on Trust websites and internal intranets, including Easy Read and Signed versions • Proactively disseminate the Disability Action Plan to key stakeholders. • Co-produced resource explaining the disability duties and legislative requirements.
All health and social care staff should be trained on disability equality and disability duties.	4. We will review our staff training programmes and ensure that training is co-produced, reflects lived experience and includes information on disability equality and the disability duties and promotes the Oliver McGowan Mandatory Training.	March 2026 Annually	• Evaluation of training completed. • Feedback on training gathered from staff to inform the evaluation. • Increased awareness of disability duties. • Co- production of training resources on disability equality and disability duties. • United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) guide for HSC staff updated.

Section 2 – Actions to encourage participation by disabled people in public life

Disabled people have told us that too often, they and their representative organisations face barriers to full and effective participation. These include inaccessible physical and online environments and inaccessible information and communication. Actions in this section focus on increasing disabled people's participation in decisions about policies and service development.

It is important to note that the Trusts do not have direct control over public life positions within health and social care, however we do have disabled people sitting on many of our user groups and forums so we have also included actions to ensure these opportunities are accessible and promoted.

As one of the largest employers in Northern Ireland, disabled people have told us that this section of the Plan must include how disabled people have the opportunity to find out about the range of jobs available in health and social care and are provided with appropriate support to enhance employability and obtain employment.

What you told us	What we will do (*Actions*)	By when	How will we measure success
Disabled People want to be clear on how they can get involved, be heard and inform decisions.	5. We will share opportunities for involvement to ensure the voice of disabled people is heard in developments and changes to services at an early stage.	March 2025	• Development of a specific database of disabled people and organisations and determine the best way for them to be involved. • Consultee database reviewed and updated annually. • Increased usage of involvement section on each Trust website and the Public Health Agency (PHA) "Engage" website and sharing of links with disabled people and representative organisations. • Promotion of Trust Involvement Teams and involvement opportunities with disabled people and representative groups. • Use of alt text in our social media.
	6. We will work in partnership with relevant key organisations and individuals to identify advocacy services.		• Development of a Directory of Advocacy and Support Services co-produced with representative organisations, published on each Trust's website (and in alternative formats) and disseminated widely - reviewed on annual basis.

What you told us	What we will do (*Actions*)	By when	How will we measure success
	7. We will invite representatives from the Regional Disabled People's Forum to work alongside the Joint Regional Equality, Human Rights and Good Relations Forum on disability equality issues.		• Annual meeting with members of Regional Disabled People's Forum and the Joint Regional Equality, Human Rights and Good Relations Forum to discuss co-produced agenda. • Change in Terms of Reference of joint forum to reflect annual meeting focusing on disability.
	8. We will review the membership of our user forums and where necessary work to increase representation of disabled people and representing organisations.		• Review of membership of forums and user groups completed. • Gaps identified where increased representation of disabled people on user groups and forums is required.

What you told us	What we will do (*Actions*)	By when	How will we measure success
Consultation methods must be accessible to disabled people.	9. We will ensure that all consultations are inclusive, targeted and use appropriate methods to ensure participation of a wide range of disabled people.		• Consultation processes designed to be as inclusive as possible from the outset. • Focused consultation with disabled participants as required • Improved opportunities for disabled people to engage with and influence policy-makers • Checklist developed that includes standards for the accessibility of public meeting areas, the provision of information in accessible formats, and the use of new technologies suitable for disabled people. • Methods and tools used for online involvement will allow disabled people to participate on a fair and equal basis.

What you told us	What we will do (*Actions*)	By when	How will we measure success
It is the responsibility of HSC staff to book communication support for people who are D/deaf and Hard of Hearing	10. We will continue the roll out of the Health and Social Care Communication Support Service for People who are d/Deaf, d/Deafblind and Hard of Hearing and improve access to Sign Video within hospitals using computers and phones accessing the Trust Wi-Fi.		• Regional consistency and equity of access to communication support for people who are Deaf/deaf or have hearing loss. • Improved access to communication support for people who are Deaf/deaf or Hard of Hearing. • Increased awareness of HSC staff of need to provide communication support. • Reduction in complaints about lack of communication support available/provided.
Consideration should be given to the installation of Changing Places toilets in all hospitals in Northern Ireland	11. We will scope the availability of Changing Places and new facilities will be added in accordance with legislation.		• Scoping of all facilities completed • Gaps identified in relation to relevant legislation • Improved access to HSC services for disabled people.

What you told us	What we will do (*Actions*)	By when	How will we measure success
Staff need to understand how to involve disabled people in decisions they make about services.	12. We will coproduce guidance for staff on how to effectively engage with disabled people in decision making processes. These guidelines will provide practical information to support staff to address the barriers to meaningfully involvement.		• Health and social care decision makers have access to good quality coproduced information and resources to improve participation of disable people in decision making. • Improved participation of disabled people in health and social care decisions.
	13. We will coproduce and hold a masterclass in each Trust area for health and social care decision makers to develop a deeper understanding of how better participation with disabled people is central to the implementation of our Disability Action Plan.		• Effective participation masterclass developed in partnership with disabled people and representative organisations. • Six masterclasses held – one in each Trust area.

What you told us	What we will do (*Actions*)	By when	How will we measure success
Policies need to be kept up to date and relevant, to support disabled staff to remain in the workplace.	14. We will review our Staff Disability Equality Policy in line with best practice to ensure it remains fit for purpose and relevant.	March 2025	• Review of Disability Equality Policy completed in partnership with disabled staff. • Revised regional policy in place.
	15. We will review and update our Disability Toolkit.		• Updated Disability Toolkit in place. • Policy and Toolkit reviewed and amended in partnership with disabled staff.
	16. We will engage with disabled staff to ensure they have a voice and influence the support we provide.		• Method of ongoing engagement established • Assessment completed on the benefits of establishing a regional HSC Trust Disabled Staff Network

What you told us	What we will do (*Actions*)	By when	How will we measure success
There is a need for more opportunities for disabled people to gain employment within health and social care.	17. We will work in collaboration with relevant stakeholders to review our employability schemes and placement schemes to enhance employment opportunities.	March 2024 scope	• Opportunities and availability of our employability schemes and placement schemes scoped.
	18. We will work to reduce barriers to recruitment in health and social care for disabled people.	April 2024-March 2028 development	• Barriers to recruitment in health and social care identified in partnership with disabled people and representative organisations • Development of actions, in line with the legislative provisions and supported by equality data, to improve access to employment for disabled people.
	19. We will provide an alternative way for disabled applicants to apply for HSC jobs until the current HSC jobs website is replaced by the new system.		• Links to this support for disabled applicants within the HSC Jobs website and landing page. • Better communication with disabled applicants who require adjustments or support with their application.

What you told us	What we will do (*Actions*)	By when	How will we measure success
There is a need to improve visibility and awareness of jobs for anyone who is disabled.	20. We will work towards Disability Positive Accreditation for all Trusts.	March 2028	• Disability Positive Accreditation achieved. • Increased awareness among disabled people of HSC jobs available.
Better data on service users communication support needs is required.	21. We will continue to work with ENCOMPASS to ensure that the communication support needs of service users are captured.	March 2028 Ongoing	• Communication support needs are recorded on the ENCOMPASS system. • Improved communication and access to services.
	22. We will support the involvement of disabled people and representative organisations in the roll out of ENCOMPASS. *(Encompass is a new Health and Social Care Northern Ireland (HSCNI) wide initiative that will introduce a digital integrated care record to Northern Ireland.)*		• Improved engagement with disabled people in the roll out of Encompass.

Contact Details

For more details of our achievements in meeting our dual disability duties, please refer to our respective Annual Progress Reports which are available online or by contacting the relevant Equality team.

www.belfasttrust.hscni.net

nias.hscni.net

www.northerntrust.hscni.net

www.setrust.hscni.net

www.southerntrust.hscni.net

www.westerntrust.hscni.net

Trust Equality Teams Contact Details

Wondering should we make this more general? Do you all have a generic email address? I have equality.unit@northerntrust.hscni.net

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20

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	9 May 2024
Title of paper:	Trust Performance Corporate Scorecard
Brief summary:	This paper is presented to Trust Board for noting the key performance indicators across the Trust for data up to and including March 2024. The Trust Performance report provides Trustboard with further details on some of these key performance indicators, including trends over time and comparisons across financial years.
Recommendation:	**For Approval** ☐ **For Noting** ☒ *Click the appropriate box*
Previous forum:	*n/a*
Prepared and presented by: **Date:**	Neil Walker (Head of Performance) Maxine Paterson (Director PP&CS) 2 May 2024

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST CORPORATE SCORECARD

NORTHERN IRELAND AMBULANCE SERVICE

April 2024

for March 2024 Data and Performance

Northern Ireland Ambulance Service
Health and Social Care Trust

Executive Summary

The Trust Performance report continues to evolve, and you will notice changes over the coming months to the report to help everyone in the organisation understand where performance is good and where we need to drive improvements.

March 2024 the Trust operated at REAP 3 Major Pressure. Although it must be noted that pressures continue across the system which is reflected in some of our performance measures in this paper. Action short of strike continues within the trust and is also impacting on some of our key performance metrics.

Demand:

- Demand for our services remains at a steady state,
  - Call answer demand in EAC has increased by 2% when comparing Financial Year 2022-23 & 2023-24.
  - Call responses have remained the same when comparing Financial Year 2022-23 & 2023-24.
  - Patients conveyed to Hospital has also decreased by 3% comparing Financial Year 2022-23 & 2023-24.

Response Times:

- Response times In March were a challenge across all categories.
- However, Category 2 response times are of significant concern deteriorating by 21mins from Quarter1 to Quarter 4 during 2023.24 and remains exceptionally high at 51mins for March 2024. This is linked to increases in delayed Handovers and has an impact on patients waiting in the community for a response.
- NIAS continues to manage Action Short of Strike (ASOS). Category 1 calls are the only calls being responded to in the last hour of shift. The end of shift protocol continues to be implemented across the trust:
  - Sending oncoming crews to ED to relieve late finished crews
  - Holding calls at the end of shift until the relieving crews is released from ED
  - Providing compensatory rest to any crew finished later than 1hr

Clinical Hear & Treat and See & Treat

- The Clinical H&T rate continued to improve and increased to 6.5% for March 24, which was a further 1.5% increase from February 24 and a 2% increase in Quarter 4. Clinical See & Treat also increased to 13.5%.

Handover:

- March 24 saw the trust lose >11k hrs with handover delays >15mins this is an increase of 6% compared with February 24, were the trust lost >10K.
- The patients waiting longer than 2hrs to handover at Emergency departments are deteriorating quarter on quarter for Financial Year 2023.24 showed very little sign of improvement.

Area	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY23.24
Region	8.8%	12.2%	19.2%	20.5%	15.0%

Patient Care Service:

- Patient experience KPIs continue to require attention to improve the experience of our patients being taken to and from appointments. We are only achieving 36% of patients making appointments on time.
- Productivity and efficiency in March 24 shows a steady state of patients per shift transported at 4.42 through March 2024.
- The productivity and efficiency metrics for the NIAS PCS crews continue to trend in a positive way over the past 6 months, which reflects the improvement work being carried out in this part of the organisation.

Serious Adverse Incidents, Complaints, Compliments and Care Opinion:

- There have been 9 potential SAIs reviewed, with the Trust notifying 2 during March 24. The trust has currently got 12 SAIs open, and they are all at level 1 review. The 8 week timeframe for submission of SAI report to SPPG remains challenging. However, improvements in the process during 23/24 have led to a reduction in delayed final report submission from an average of 62 days overdue to 31 days overdue.
- During March 2024, the Trust received 27 complaints and 32 compliments, along with 6 stories submitted via care opinion during February 23. 23/24 Performance against the 2 day acknowledgement KPI has been strong at 99% however a number of factors have impacted on the response within 20-day timeframe (43%). The Trust however have had no cases referred through the Northern Ireland Public Service Ombudsman (NIPSO) and of 234 complaints received in 23/24, just over 1% of cases (n=3) complaints required to be re-opened.

Absence Management:

- The Financial Year Sickness absence rate is 14.23% for the trust. March 2024, was the best performing month for sickness absence this year at 10.70%.
- 68% of the Trusts sickness absence is contained within the following categories (Mental Health, Injury | Fracture, Miscellaneous, Influenza and Untoward accident).
- The largest category for sickness absence within the trust is for mental health reasons, with stress being the prevalent reason.

Northern Ireland Ambulance Service CORPORATE SCORECARD 2023/24

March 2024

Northern Ireland Ambulance Service Health and Social Care Trust

Indicator	Measure	Detail	Latest Reported Period												2023/24 Target	Reporting Frequency
Our Patients will be professionally cared for: Always with compassion and respect			Outturn 22/23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24		
1.01	Category 1 Mean Response Time	The Average Time taken to respond to a Category 1 Call	10	9	10	10	11	11	11	11	11	12	13	12	12	10 mins	Monthly
1.02	Category 1 90th Centile Response Time	The time taken to respond to 90% of Category 1 Calls	21	19	20	20	21	23	22	22	22	23	25	23	24	21 mins	Monthly
1.03	Category 1T Mean Response Time	The Average Time taken to respond to a Category 1 Call with Transport	13	13	14	14	14	15	15	16	15	16	17	16	15	13 mins	Monthly
1.04	Category 1T 90th Centile Response Time	The time taken to respond to 90% of Category 1 Calls with Transport	27	26	27	29	27	32	28	31	27	32	34	30	29	30 mins	Monthly
1.05	Category 2 Mean Response Time	The Average Time taken to respond to a Category 2 Call	36	31	31	37	38	44	47	51	47	73	70	59	52	35 mins	Monthly
1.06	Category 2 90th Centile Response Time	The time taken to respond to 90% of Category 2 Calls	80	68	69	81	84	100	105	111	102	167	160	134	115	80 mins	Monthly
1.07	Category 3 90th Centile Response Time	The time taken to respond to 90% of Category 3 Calls	233	183	196	262	280	360	328	483	363	532	513	375	333	233 mins	Monthly
1.08	Call Answering Performance	% of calls answered within 5 Secs	89.5%	86.9%	85.3%	82.4%	80.7%	80.2%	82.2%	85%	86%	86%	89%	86%	90%	90%	Monthly
1.09	No. of Calls Answered within Emergency Ambulance Control	Number of Calls Answered within EAC each month (Emergency 999 calls)	20,789	16,595	18,106	18,440	18,939	19,564	19,187	20,336	19,046	22,548	21,424	16,701	19,521	N/A	Monthly
Our Staff will feel positive and proud to work for NIAS																	
2.01	Cumulative % Hours lost from Sickness	Total Hours lost due to sickness absence/Total hours available (%). Year to Date 2023/24	12.15%	14.25%	14.20%	14.25%	14.27%	14.64%	14.60%	14.65%	14.82%	14.90%	14.76%	14.53%	14.23%	11.2%	Monthly
2.02	Cumulative % Hours lost from Short Term Sickness	Total Hours lost due to Short Term sickness absence/Total hours available (%). Year to Date 2023/24	2.72%	2.57%	2.20%	2.33%	2.35%	2.55%	2.61%	2.63%	2.67%	2.74%	2.82%	2.83%	2.77%	N/A	Monthly
2.03	Cumulative % Hours lost from Long Term Sickness	Total Hours lost due to Long Term sickness absence/Total hours available (%). Year to Date 2023/24	9.43%	11.68%	12.00%	11.92%	11.92%	12.09%	11.99%	12.02%	12.15%	12.16%	11.94%	11.70%	11.46%	N/A	Monthly
2.04	Organisational Vacancy rate	Percentage of Vacancies within the Trust															Monthly
2.05	Cumulative Staff Turnover rate	Percentage of turnover of staff within the Trust over the past 12 months		5.13%	5.06%	5.77%	5.95%	6.20%	6.00%	5.80%							Monthly
2.06	Staff Engagement Survey	Number of Staff Engagement Surveys Complete															
2.07	Statutory and Mandatory Training	Percentage of Staff that have completed Statutory and Mandatory training	20.0%														TBC
Our Stakeholders and partners will have confidence in us as a reliable provider at the centre of USC																	
3.01	Average Handover Time at Type 1 ED	The average time it takes to hand a patient over to a Type 1 Hospital ED	64	56	53	57	60	64	66	85	78	89	104	84	82	15 mins	Monthly
3.02	Lost Hours from Handover delays >15mins	The Hours lost from handovers exceeding the 15min target at Type 1 EDs	8,967	9,780	9,861	7,686	8,425	8,978	8,748	12,035	10,649	12,145	14,242	10,518	11,218	N/A	Monthly
3.03	Number of Patients >2hrs for Handover	Number of Patients that wait >2hrs to be handed over at Type 1 EDs	16,286	991	880	1,028	1,205	1,369	1,332	2,087	1,814	1,983	2,345	1,758	1,894	0	Monthly
3.04	Hear & Treat Rate	The percentage of patients being clinically treated via the Clinical Hub within Emergency Ambulance Control	4.2%	3.5%	3.2%	4.5%	4.0%	3.4%	4.0%	3.9%	3.8%	4.4%	4.5%	5.0%	6.5%	5.2%	Monthly
3.05	See and Treat Rate	The Percentage of patients being clinically treated at Scene by the Ambulance Crews	14.2%	14.0%	14.4%	14.8%	14.8%	14.5%	14.3%	14.6%	14.1%	13.8%	14.3%	14.1%	13.5%	15.2%	Monthly
3.06	Conveyance Rate	The Percentage of patients being conveyed to Hospital	81.6%	82.50%	82.40%	80.70%	81.20%	82.10%	81.70%	81.48%	82.10%	81.80%	81.20%	80.90%	79.95%	N/A	Monthly
3.07	Number of Scheduled journeys made	The number of journeys to and from a Healthcare facility by NIAS Patient Care Service resources	157,507	12,167	13,345	13,845	12,840	13,256	12,426	12,641	13,070	12,147	12,825	12,424	12,648		Monthly
3.08	Average Number of Patient Journeys per shift	The Average number of patients transported by PCS resources within each shift	3.65	3.58	3.70	3.80	3.89	3.90	3.84	4.29	4.32	4.15	4.25	4.48	4.42	N/A	Monthly
3.09	Average Number of Patient transported per Run	The Average number of patients transported to a healthcare facility per Run	1.19	1.19	1.19	1.23	1.26	1.23	1.23	1.36	1.37	1.37	1.36	1.39	1.44	N/A	Monthly
3.10	The Percentage of patient Journeys that arrive on time	The percentage of PCS journeys that arrive within 60mins of the patients appointment time.	30%	39%	36%	36%	39%	37%	37%	34%	37%	40%	35%	34%	36%	95%	Monthly
3.11	The Percentage of patient Journeys that start on time	The Percentage of journeys that start within 60mins of the patient being booked ready by the healthcare facility	56%	70%	71%	70%	70%	68%	67%	68%	67%	66%	65%	73%	68%	95%	Monthly
Our Communities will continue to value and trust us																	
4.01	Number of potential SAIs reviewed	The number of potential SAIs that have been reviewed by the Trust	135	13	9	11	18	13	13	21	14	11	13	10	9	N/A	Monthly
4.02	Number of SAIs notified	The number of SAIs that have been notified to SPPG	42	3	3	2	0	5	4	6	8	8	1	4	2	N/A	Monthly
4.03	Number of Complaints	The number of complaints that have been received within the month by the trust for investigation	148	17	15	11	16	15	22	23	29	20	18	21	27	N/A	Monthly
4.04	Number of Compliments	The number of Compliments that have been received within the month by the Trust	272	58	41	36	32	29	36	31	34	16	32	37	32	N/A	Monthly
4.05	Nmber of patient stories received	The number of patient stories submitted within the month to the Trust	128	23	20	14	16	20	12	14	11	6	9	11	6	N/A	Monthly
		Forecast Deficit / Surplus for YE against total revenue resource limit															

Northern Ireland Ambulance Service
Health and Social Care Trust

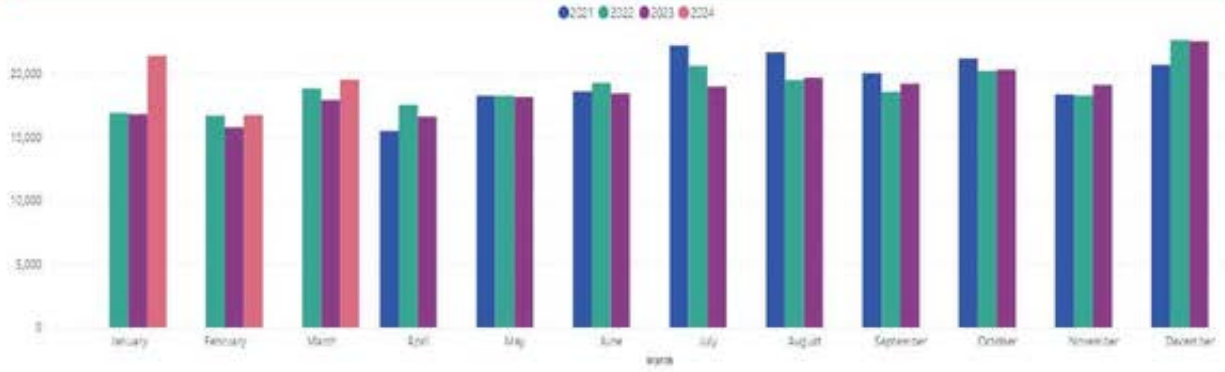
Our Patients | Emergency Demand Performance | Operational Demand

The level of demand each month has a direct relationship on our performance metrics. Ensuring we make the most appropriate response is critical to managing demand effectively and therefore making the most of our resources and capacity to respond to our most critical patients.

The analysis below describes: Calls Answered and Call Answering Performance

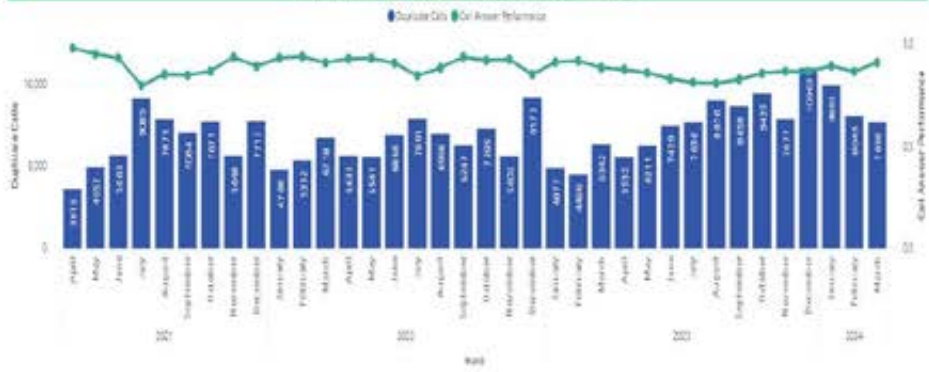
999 Calls Answered

Monthly Demand



Call Answering Performance and Duplicate Calls

Duplicate Calls (N) compared with Call Answer Performance (%)



- **March 24** has seen an increase in demand levels of 9% when compared with March 2023. The Financial Year demand for 2023-24 has been 2% more than the Financial Year 2022.23. In the same period, **Incidents** the trust has had to respond to have remained static Year to date 2023-24 to 2022-23.
- **March 2024** saw an average of 630 calls per day being answered by EAC and this was mirrored across ambulance services in England.
- **Call Answering performance** continued to be a challenge through March 24 as staffing challenges within the control room persisted at weekends. However, **March 2024 call answering performance recovered to 90%** for the month, which is a continued improvement in the trusts call answer performance.
- **Duplicate Calls** continued to decrease in March 2024 from the peak in December 2023, however duplicates persist at a high level just over 7,000

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | 999 Response Time Performance | Response Times Scorecard

Latest Month	Mar-24

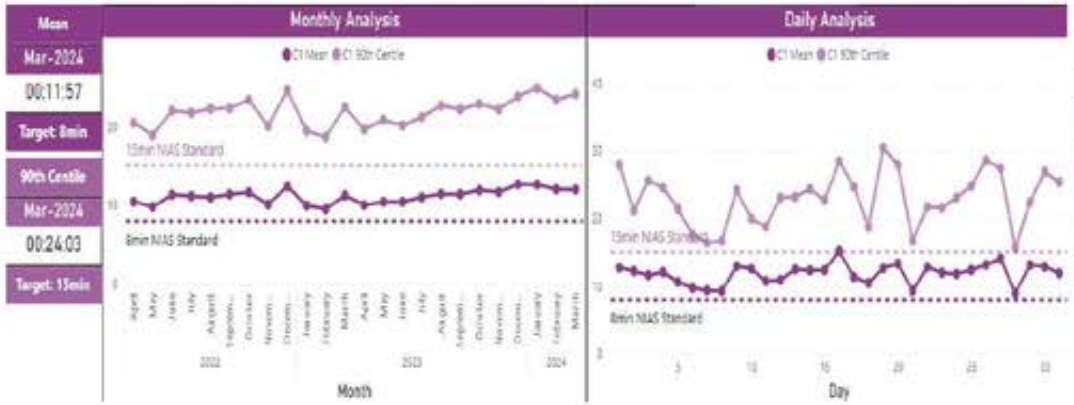
	Target	Current Performance: Latest Month	Current Performance: YTD (from April)	Current Performance: Rolling 12 Month	Benchmarking (Latest Month): National Data	Benchmarking (Latest Month): Best in Class	Benchmarking (Latest Month): Ranking (out of 12)
Category 1 response - Mean	8 Minutes	00:11:57	00:11:30	00:11:30	00:08:20	00:06:58	(Blank)
Category 1 response - 90th Centile	15 Minutes	00:24:03	00:22:24	00:22:24	00:14:48	00:12:14	(Blank)
Category 1T response - Mean	19 Minutes	00:15:12	00:15:02	00:15:02	00:10:16	00:08:05	(Blank)
Category 1T response - 90th Centile	30 Minutes	00:29:12	00:29:46	00:29:46	00:18:39	00:14:08	(Blank)
Category 2 response - Mean	18 Minutes	00:51:59	00:48:09	00:48:09	00:33:50	00:24:22	(Blank)
Category 2 response - 90th Centile	40 Minutes	01:55:00	01:46:31	01:46:31	01:11:51	00:48:32	(Blank)
Category 3 response - Mean	Not a target	02:03:00	02:12:51	02:12:51	02:03:47	01:05:48	(Blank)
Category 3 response - 90th Centile	2 Hours	05:35:39	05:37:45	05:37:45	04:52:42	02:42:55	(Blank)
Category 4 response - Mean	Not a target	02:00:00	03:39:33	03:39:33	02:29:48	01:37:15	(Blank)
Category 4 response - 90th Centile	3 Hours	05:31:30	10:52:40	10:52:40	06:02:39	03:34:40	(Blank)

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | **999 Response Time Performance** | **Response Times**

CATEGORY 1 and CATEGORY 2 Response Times are measured based on the mean and the 90th centile of the response time provided.
The target for a CATEGORY 1 call response time is 8 minutes (15 minutes for the 90th centile).
The target for a CATEGORY 2 call response time is 18 minutes (40 minutes for the 90th centile).

CATEGORY 1 Performance



CATEGORY 2 Performance

Category 1

- March 24 Category 1 mean response time was 11 minutes 57 seconds; while the Category 1 90th centile was 24 minutes 03 seconds.
- March 24 continues to see a challenging Category 1 mean response. This is replicated on the Category 1 90th centile performance.

Category 2

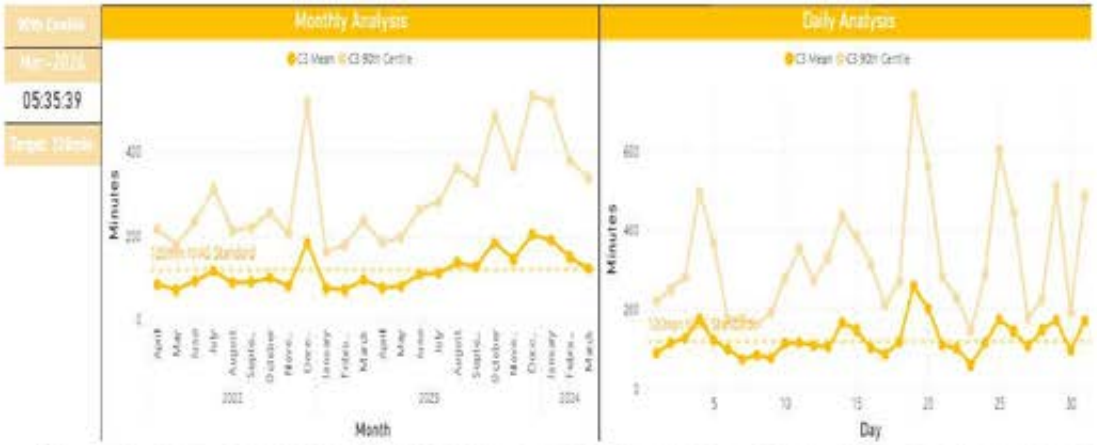
- March 2024 Category 2 mean response time was 51 minutes 59 seconds; while the Category 2 90th centile was 1 hours 55 minutes.
- Both the Category 2 mean and 90th centile response times remain a challenge in March 24. There are a number of actions that have been particularly impactful on performance:-
  - Persistence in handover delays >2hr, outlined in slides further in this paper.
  - Action short of Strike (ASOS) is impacting our category 2 response times.
  - Realising crews at ED at the end of shift with oncoming crews.
  - Providing staff with compensatory rest for those late finishes over 1hr.
- The delay in this category 2 response time is having a significant impact on patient safety

Northern Ireland Ambulance Service
Health and Social Care Trust

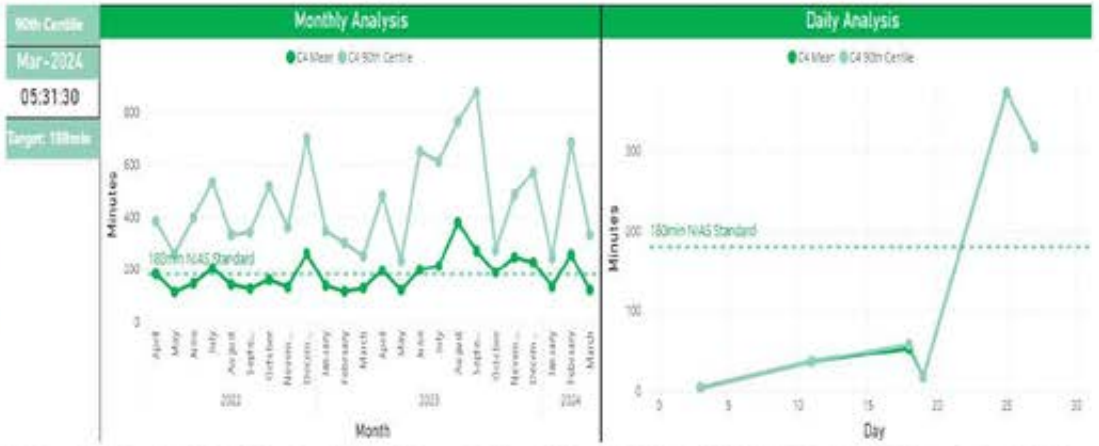
Our Patients | **999 Response Time Performance** | **Response Times**

CATEGORY 3 and CATEGORY 4 Response Times are measured based on the 90th centile of the response time provided.

CATEGORY 3 Performance



CATEGORY 4 Performance



Category 3

- March 24 Category 3 mean response time was 2 hours 03 minutes; while the Category 3 90th centile was 5 hours 35 minutes and 39 seconds, over 3 hours above target.
- As outlined in the previous slide, category 3 response times are impacted by the same root causes.

Category 4

- March 24 Category 4 mean response time was 2 hours; while the Category 4 90th centile was 5 hours 31 minutes and 30 seconds. It must be noted that the volume of Category 4 calls received by NIAS is very low and response times can be impacted significantly on a daily basis.

Northern Ireland Ambulance Service
Health and Social Care Trust

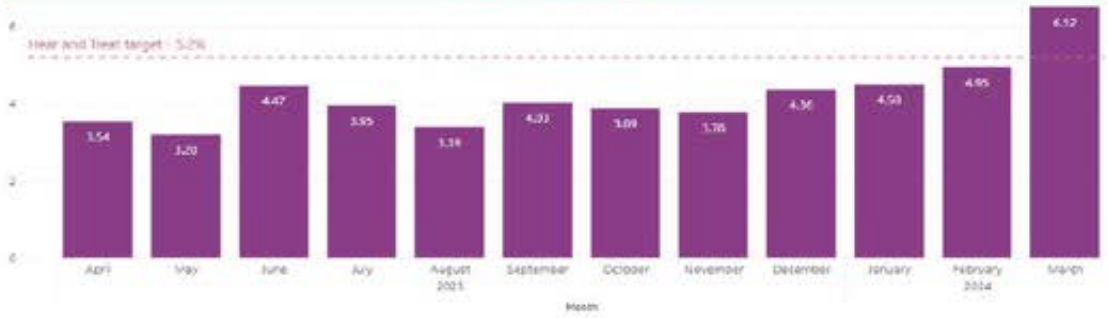
Our Patients | Emergency Demand Performance | Clinical Response

The level of demand each month has a direct relationship on our performance metrics. Ensuring we make the most appropriate response is critical to managing demand effectively and therefore making the most of our resources and capacity to respond to our most critical patients.

The analysis below describes: NIAS Clinical Hear & Treat and Clinical See & Treat

Clinical Hear & Treat

Monthly Hear and Treat %



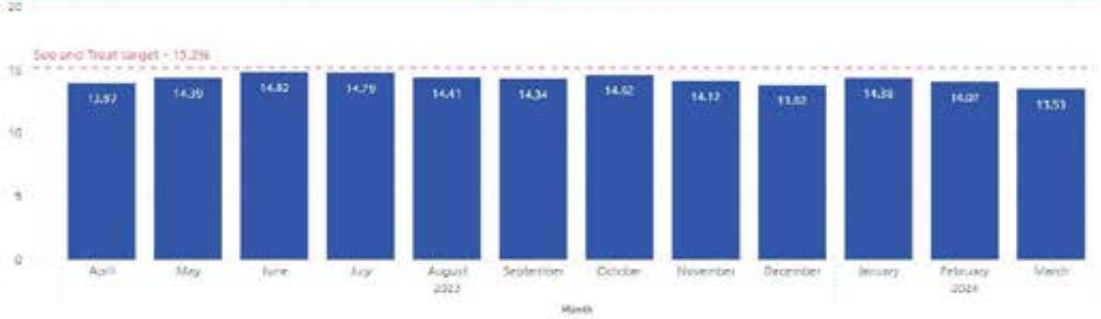
March 2024 saw the go live of the recently recruited Integrated Clinical Hub Clinicians. The benefit of these clinicians can be seen as the number of patients receiving a Hear & Treat outcome rose by more than 40% on the previous month.

As can be seen from the chart above, the Hear & Treat rate has now improved each month since November 2023 and we now have a run of data points indicating a stepped improvement in the Trust's Hear & Treat rate.

The aimed improvement trajectory is to increase Hear & Treat by a further 1.5% by 31st March 2024.

Clinical See & Treat

Monthly See & Treat %



As with Hear & Treat, a revised See & Treat dashboard has been finalised, which will allow for analysis of practice down to station level.

NIAS has developed a suite of care pathways and alternative destinations to provide a range of alternatives to the Emergency Department referral pathway.

Increasing See & Treat use will require education and support of clinicians to ensure safe and effective changes in practice. A supportive education package is being developed.

The aimed improvement trajectory is to increase See & Treat by a further 1.5% by 31st March 2024.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Performance | Hospital Handover Performance

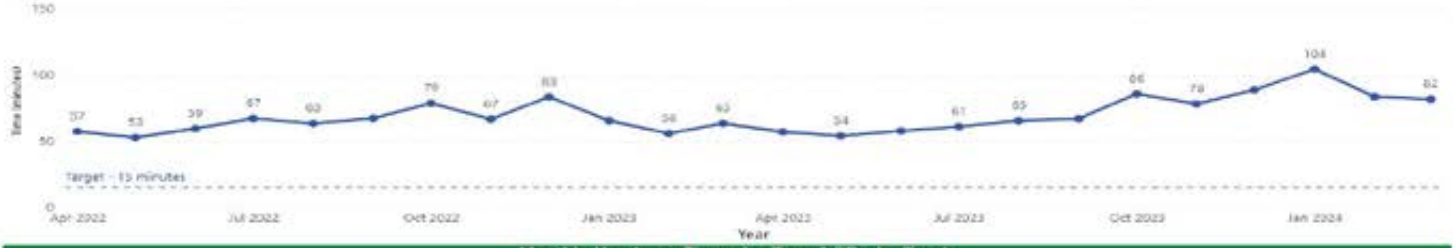
Our operational efficiency is critical to our success. One of our key dependencies is the ability to handover a patient in a timely manner when conveyed to hospital. As such, we must strive to be as efficient as possible whilst always delivering the very best care for our patients.

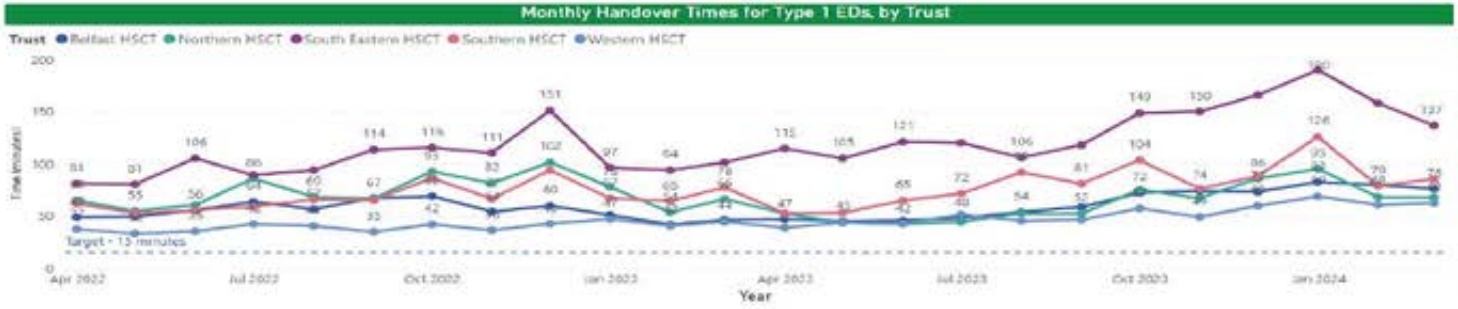
Arrival at Hospital to Patient Handover

Hospital Attended	Total Attendances	Total Handovers	Total Handovers Over 15mins	% Over 15mins	Total Handovers over 60mins	% Over 60mins	Total Time Lost (Hours)	Average Handover Time (Minutes)
ULSTER	1359	1359	1285	94.55%	746	54.89%	2,773.85	137.23
CRAIGAVON AREA	1215	1215	1140	93.83%	523	43.05%	1,737.11	100.48
ROYAL GROUP	2141	2141	1987	93.27%	976	45.59%	3,475.85	84.07
CAUSEWAY	622	622	586	94.21%	254	40.84%	651.49	77.60
ALTNAGELVIN	1214	1214	1157	95.30%	553	45.55%	1,170.96	72.65
ANTRIM AREA	1705	1705	1602	93.96%	487	28.56%	1,411.35	64.41
DAISYHILL	561	561	522	93.05%	158	28.16%	363.96	53.61
MATER	478	478	437	91.42%	116	24.27%	302.36	52.67
SOUTH WEST	583	583	526	90.22%	93	15.95%	250.62	41.20
DOWNE	27	27	17	62.96%	4	14.81%	10.65	36.83
LAGAN VALLEY	94	94	53	63.10%	9	10.71%	28.64	34.01
RBSC	133	133	87	65.41%	5	3.76%	25.82	24.91
BELFAST CITY	47	47	32	68.09%	2	4.26%	7.04	22.52
Total	**10169**	**10169**	**9441**	**92.84%**	**3926**	**38.61%**	**11,218.00**	**80.87**

Total Time Lost (Hours) - Last 12 months

119,826.72





In March 2024, NIAS experienced a total of 11,218 lost hours. This is the equivalent of 30 shifts per day where crews are waiting with patients outside EDs; 26% of our planned capacity. These lost hours were experienced from 9,441 instances where our crews waited longer than 15mins to handover their patient at ED. 3,926 handovers took longer than an hour in March 2024

In March 24, >75% of the 11,218 lost hours occurred at the four ED sites listed below in order of hours lost:

- *Ulster Hospital (2.7k hours; 95% > 15min; 55% > 1hr)*
- *Craigavon Hospital (1.7k hours; 94% > 15min; 43% > 1hr)*
- *Royal Victoria (2.4k hours; 93% > 15min; 46% > 1hr)*
- *Antrim Area (1.4k hours; 94% > 15min; 29% > 1hr)*

In the Financial Year 2023.24, >93% of the handovers exceeded the 15min target at our acute EDs, resulting in circa 119k hours lost. The lost hours experienced in March 24 is a increase of 701 hrs or 6% from February 24, whilst the number of instance of delayed handovers also increased by 9% in the same period.

The 11,218 operational hours being lost are equivalent to 934 12-hours shifts per month, or 30 12-hour shifts per day.

Northern Ireland Ambulance Service
Health and Social Care Trust

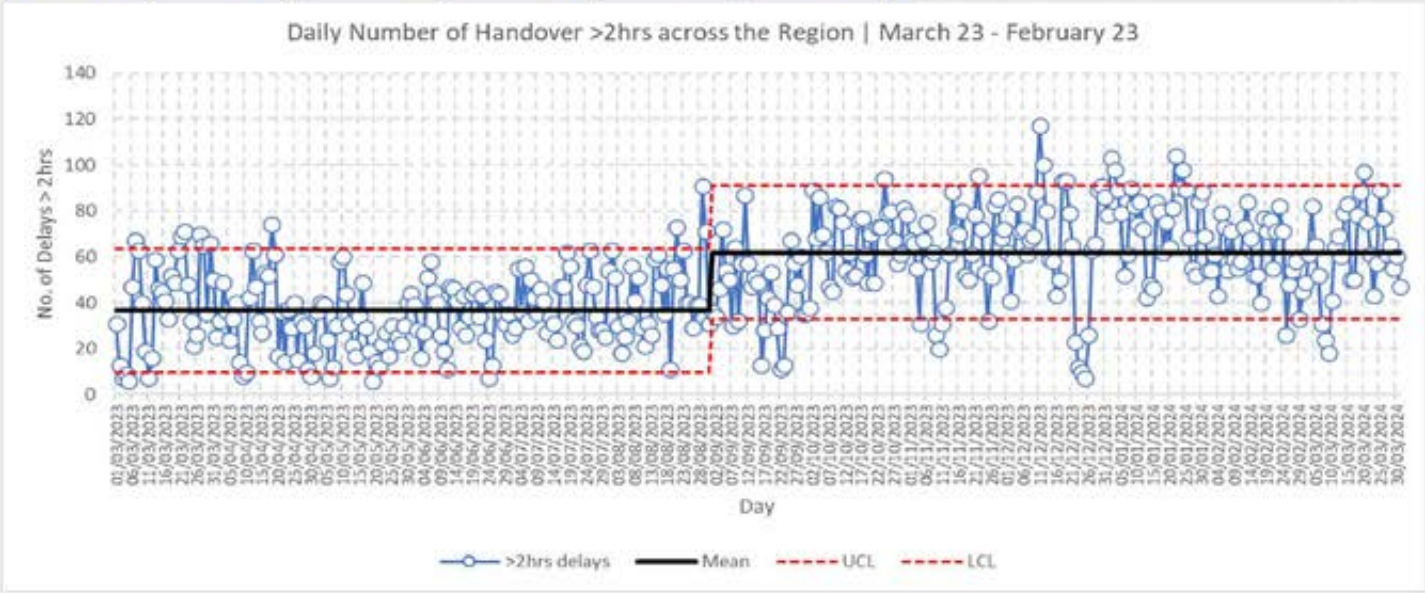
Our Patients | **Emergency Performance** | **2hr Back Stop Regional Performance**

Our operational efficiency is critical to our success. One of our key dependencies is the ability to handover a patient in a timely manner when conveyed to hospital. As such, we must strive to be as efficient as possible whilst always delivering the very best care for our patients.

Area	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY23.24
South Eastern	21.1%	23.5%	32.8%	34.7%	27.7%
Southern	9.5%	18.8%	20.2%	21.6%	17.3%
Belfast	6.6%	9.8%	18.9%	20.1%	13.5%
Northern	5.4%	7.2%	17.2%	17.3%	11.5%
Western	2.8%	5.3%	8.1%	11.1%	6.8%
Region	8.8%	12.2%	19.2%	20.5%	15.0%

The table shows the deterioration in >2hr delays by trust from March 2023. March 2024 has saw the 2hr handover position stagnate.

There has been a quarter-on-quarter decline since the introduction of the 2hr backstop across the region. In 2023.24 some areas over a quarter of patients have experience a >2hr delay to get into an Emergency department. Whilst 15% of patients across the Region were delayed over 2hrs to access ED.



The chart to the left is a statistical Process Control (SPC) chart, outlining the variation in the handover process. Since March 23, the has been a step decline in the 2hr backstop performance.

The trust is now experiencing an average 62 patients per day being delayed >2hrs before being admitted into Emergency departments across the region.

This SPC chart strongly indicates that the processes to reduce the 2hr handover delays are showing no signs of control over the past number of months.

The desirable trend would be one that shows a sustained run of data points below the centre line, trending towards zero driving an outcome of sustaining zero handovers >2hrs.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | **Non-Emergency Performance** | **Productivity Performance**

Patient-focused KPIs

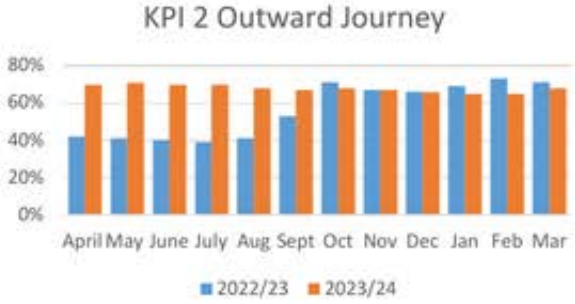
KPI 1 - That 95% of inward journeys will arrive within the 60mins prior to an appointment time.

Performance against KPI 1 remains poor at 35% - further analysis is required to determine the extent of non compliance in terms of time of arrival – it may be necessary to reconsider the time parameter.

The Patient & Public Involvement team will be engaging with the NIAS Patient Voice Forum to determine how best to involve patients in the development of patient experience related KPIs

KPI 2 - That 95% of outward journeys will start within 60 minutes of the patient being booked as ready by the clinic/hospital

- October 2023 seen the commencement of Destination Focused Planning which has resulted in improvements in the KPI 2 – Outward journeys, however the % compliance has remained static at approx. 60%. Ongoing improvements efforts are underway to increase compliance including actions relating to Attendance management
- Determining model of need to inform required rota changes
- Continued destination focussed planning actions.



Productivity & Efficiency KPIs (NIAS crews only)

KPI - Average Number of Patients Transported per Shift

The notable improvement in this indicator of activity from Oct both has largely been maintained with a slight drop in Dec (due to the no of Public Holidays when there would be limited Clinics).
This can largely be attributed to the commencement of Destination Focused Planning in Oct 23.

KPI - Average Number of Patients Transported per Journey (Run)

As above there has been a significant improvement in this measurement since Oct for the same reason.

To underline these figures NIAS crews carried out on average approx. 1000 more patient journeys in each month since Oct '23 when compared to the same month in 2022/23

Points to Note

- Compliance against KPIs 1 & 2 relates to Ambulance Journeys where timestamps have been completed. Timestamp compliance rates in Mar' 24 = NIAS 81.45%
- We are currently working to develop a comprehensive set of productivity indicators and while these are being worked on in the PCS Improvement Project, we will continue to report on Patients transported and Patients per journey. It remains the aim to be able in the near future to report on more specific utilisation and productivity indicators such as productive time v unproductive time.

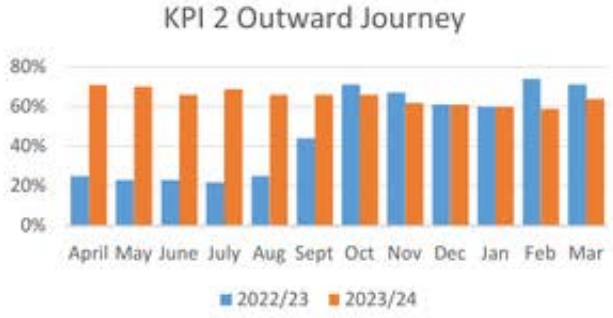
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | **IAS Non-Emergency Performance** | **IAS Productivity Performance**

Patient-focused KPIs

KPI 1 - That 95% of inward journeys will arrive within the 60mins prior to an appointment time.
KPI 2 - That 95% of outward journeys will start within 60 minutes of the patient being booked as ready by the clinic/hospital

It should be noted that in the early part of 2022/23 there was very poor and inconsistent data collection methods in use with the Independent Ambulance Sector. As part of the PCS Improvement Programme this was addressed during 2022/23



Productivity & Efficiency KPIs (IAS crews only)

KPI - Average Number of Patients Transported per Shift

There is noted monthly variation in this indicator. Further work is required to improve our understanding of the factors influencing variation.

It should also be noted that length of IAS shifts can vary significantly depending of the service need that they are employed to meet on a day to day basis.

KPI - Average Number of Patients Transported per Journey (Run)

Gradual Improvement in this measure is reflective of a discontinuation of Covid measures that had been restricting the number of patients that could be on the same vehicle and the recent improvement focus on destination planning to better utilise the carrying capacity of vehicles.

Points to Note

- Compliance against KPIs 1 & 2 relates to Ambulance Journeys where timestamps have been completed. The no. of IAS journeys with complete timestamp information has varied significantly during the year in Mar '24 this was at 93.7% compliance.
- These reporting measures for IAS non-emergency performance mirror the reporting measures for NIAS non-emergency performance in 2023/24 and will also be developed to a more comprehensive suite of measures going forward.

NB It should be noted that the IAS activity reported on doesn't include activity delivered under the "Covid Sitting Case Arrangements" that were discontinued in Sept '23

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Performance | Actions to Improve Performance

- Planning has commenced to identify the key projects for the delivering value programme for 2024.25, service improvements will be identified and implemented through the programme and regular updates will be provided to Trustboard throughout the year.
- Additional mitigation has been employed at the end and start of shifts to reduce the impact of late finishes on staff. The Trust is currently using its own staff to relieve crews at ED. This essentially means that these crews coming on shift are tasked to make their way to Emergency Departments to allow those crews finishing to get away as close to their finish time as possible.
- Newly appointed Integrated clinical hub clinicians are now in post following their training, with the new rota now implemented through March 2024. This Rota is based on call demand for the service, with a focus on ensuring staffing levels meet the call demand as it commences within the trust. Performance management and clinical audit mechanisms have been strategically implemented to quantify and understand the hub's impact, aiming to optimise its full potential.
- Additional HALO positions are now filled to support Emergency Departments & crews during handover of patients at Emergency Departments.
- Newly Qualified Paramedics, Qualified Paramedics and qualified Emergency Medical Technicians staff commenced on 3rd April 2024. There were 6 QPs, 5 NQPs and 2 Qualified EMTs that joined the trust. In addition, there was also a Qualified Paramedic and Qualified EMT that joined the trusts Bank.
- Work is being prioritised to develop principles and approaches to introducing enhanced rotas to support staff health and wellbeing, along with delivering operational cover during times patients require the Trusts services.
- Improved utilisation of alternative care pathway and destinations to support our data to provide enhanced planning tools across operations and to remove admin processes that take away operational hours for our station officers;
- A continued focus on Patient Care Pathways to maximise opportunities, signpost patients appropriately, and contribute to reducing conveyance rates. Meeting planned with SET to audit the clinical presentations of those low acuity patients discharged from EDs.
- Challenges with Duplicate Call activity and staffing in EAC have been highlighted earlier in the performance report. EAC have reviewed the process and how we can address this and have plans to mitigate
- NIAS have committed to work with GIRFT colleagues to develop a full understanding of the regional Directory of Services (DOS) and actions to deliver this recommendations will be taken forward with support from our RCC affiliates.

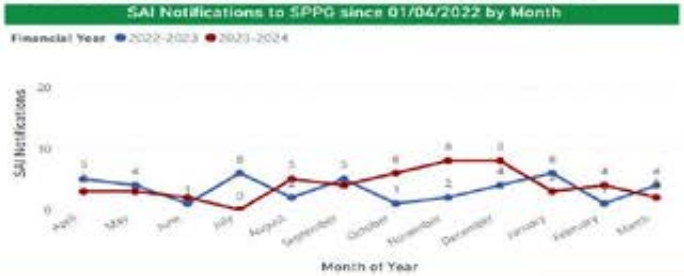
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients

SAIs & Complaints

Serious Adverse Incidents

During March 2024, the Trust reviewed 9 potential SAI's resulting in 2 notifications to SPPG.
From April 2023 – March 2024, the Trust reviewed 155 potential SAI's resulting in a total of 48 notifications to SPPG. All incidents were notified as Level 1 reviews.



Themes

The 3 key National Ambulance Risk and Safety Forum themes Identified during March 2024 are as follows:

- Delays in call answering and dispatch
- Call Handling & Dispatch Incidents
- Clinical Assessment and or treatment on scene

The top NIAS themes are as follows:

- Delayed response out with standard associated with a patient outcome of death
- Deteriorating Patient – community
- Elderly patients who have fallen

Recommendations & Learning

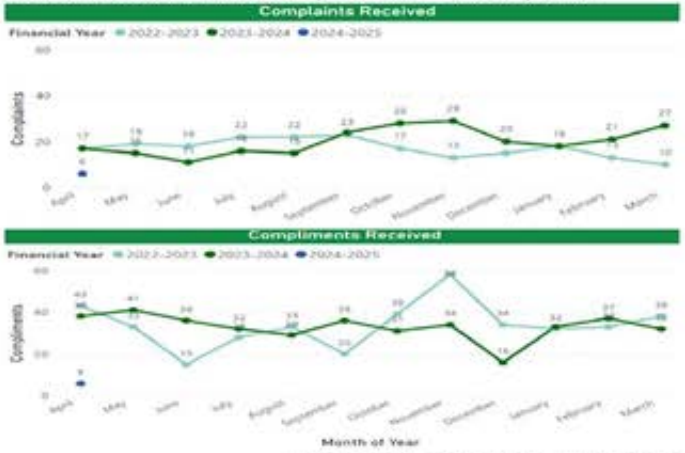
During March 2024, 5 SAI's were closed with the following learning identified:

- Importance of adherence to the procedure for the processing of duplicate calls.
- Importance of documenting rationale for out of sequence dispatch decisions
- Staffing challenges within CSD/CSM impacting timely provision of welfare calls to patients experiencing protracted delays for ambulance response

From April 2023 – March 2024, NIAS completed and closed 47 SAI's with learning identified.
Implementation and evidencing of SAI recommendations has been an area of renewed focus throughout 23/24 and to date we have completed and evidenced 74% of the outstanding SAI recommendations.

Complaints, Compliments & Care Opinion

During March 2024, **32 compliments** & **27 complaints** were received. 2023.24 saw 395 compliments & 241 Complaints



Timeliness of Process

27 complaints were closed during March 2024. FY 2023.24 the trust closed 232 complaints.

At the end of March 2024, 39 complaints remained opened with the average number of days opened being 36 working days.
Trends &Learning: Of the 241 complaints received, 309 subjects of concern were recorded. Of the 309 subjects of concern raised, 117 (38%) related to a delay (both A&E and PCS), 70 (23%) related to staff attitude and 39 (13%) related to the quality of care and treatment provided. These resulted in 117 learning outcome recommendations, of which 90 were completed by the financial year end.

Service Improvement Plans completed during 23/24

- Feedback leaflet for frontline staff to issue to service users
- Development of learning outcomes action dashboard
- Refresh of public facing feedback sections of external website
- Feedback survey for complainants & staff to complete following resolution of the complaint.

Care Opinion

During March 2024, 6 stories were submitted via Care Opinion and 162 stories were submitted in FY 2023.24 .

The main areas of feedback were:
What's good – Paramedics/ Professional / Communication
Improvements – Communication / Ambulance wait / Staff attitude
Feelings – Thankful / Grateful / Comfortable

Northern Ireland Ambulance Service
Health and Social Care Trust

Our People | Absence | Sickness

Maximising Attendance has been taken out of Business As Usual and managed via a project chaired by the Director of HR&OD and an Assistant Director of Operations. A Delivery Plan was developed to deliver improvement with related performance overseen by the Project Board and onward to SMT and the Trust's People, Finance and Organisational Development Committee. Enhanced accountability mechanisms have also been established by the Chief Executive with each directorate.

Managerial action has focused on the central role of the line manager in the management of absence, supported by HROD colleagues. An information-led approach has been an important factor in this work.

Post-Covid, a significantly higher number of staff have sought redeployment on medical grounds to other roles than would normally have been expected. It has proved challenging to identify suitable alternative employment for these individuals, particularly in the context of increased scrutiny in relation to the filling of vacancies. To date, of those identified as being appropriate for consideration of medical redeployment, 67% have been, or are in the process of being, redeployed to permanent or temporary posts.

Top 5 Sickness Categories 2023/24*	
Mental Health	30.21%
Injury, Fracture	12.28%
Miscellaneous	10.32%
Influenza	8.08%
Accident/Untoward Incident	7.71%

* Accounts for 68.60% of absence

Miscellaneous includes General Debility (4.97%); Hospital Investigations (2.30%); Post Surgical Debility (1.57%); Post Viral Fatigue (1.17%); Chronic Fatigue (0.28%)

Mental Health Reasons	
Stress	14.52%
Stress-Work Related	7.64%
Anxiety	2.83%
Grief/Bereavement	2.72%
Other Mental Health	1.30%
Depression	0.61%
Panic attacks	0.38%
Insomnia	0.05%
Behavioural Disorder	0.08%

Sickness absence due to mental health reasons represents 30.00% of sickness absence in 2023/24, with stress and work-related stress accounting for 15.01% and 7.38% (22.39% in total) respectively. The Trust's Health & Well-Being Team continue to implement the Trust's Mental Health Action Plan as part of the Healthy People, Health Place Strategy, including raising awareness and offering manager training in the use of the Trust's policy and procedure on managing work-related stress.

2023/24 Cumulative Sickness Absence by Month including Comparison with Previous Reporting Year

	Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1.	Absence Target (2023/24)	11.24%[1]											
2.	Current Status against Target	14.23% ↓											
3.	Cumulative % hours lost (22/23)	10.62%	10.64%	10.88%	10.94%	10.89%	10.93%	11.12%	11.19%	11.58%	11.91%	12.07%	12.30%
4.	Cumulative % hours lost (23/24) (Total)	14.25%	14.19%	14.25%	14.27%	14.64%	14.60%	14.65%	14.82%	14.90%	14.76%	14.53%	14.23%
4.1	Cumulative % hours lost (23/24) (Non-Covid)	13.15%	13.27%	13.40%	13.46%	13.71%	13.33%	13.44%	13.88%	13.94%	13.78%	13.58%	13.33%
4.2	Cumulative % hours lost (23/24) (Covid)	1.1%	0.95%	0.85%	0.81%	0.93%	1.02%	1.04%	0.94%	0.96%	0.98%	0.95%	0.90%
4.3	Cumulative % hours lost (23/24) Short-Term	2.57%	2.20%	2.33%	2.35%	2.55%	2.61%	2.63%	2.67%	2.74%	2.82%	2.83%	2.77%
4.4	Cumulative % hours lost (23/24) Long-Term	11.68%	12.00%	11.92%	11.92%	12.09%	11.99%	12.02%	12.15%	12.16%	11.94%	11.70%	11.46%
5.	Monthly % hours lost (23/24) Total	14.25%	14.13%	14.36%	14.34%	16.04%	14.41%	14.91%	16.01%	15.56%	13.60%	12.08%	10.70%
6.	Average standard working days lost/employee/month	2.78	2.98	3.01	2.93	3.60	2.94	3.19	3.43	3.19	3.05	2.47	2.19
7.	Average estimated cost per month (£'000)	860	859	859	822	£911	£820	£840	£890	£858	£739	£643	£534

[1]To reduce absence rates to 92.5% of absence levels reported in 2022/23 (based on annual re-run) by end March the 2023/24 financial year.

↑ Above target and increase from last month
↓ Above target and decrease from last month
↑ Below target and increase from last month
↓ Below target and decrease from last month

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

The information below sets out the Trajectories agreed with SPPG for 2023-24 and our performance against these trajectories

Call Answer Performance:

	April 23	May 23	June 23	July 23	August 23	September 23	October 23	November 23	December 23	January 24	February 24	March 24
Call Answer Outturn	86.9%	85.3%	82.4%	80.7%	80.2%	82.2%	85.1%	86.1%	85.9%	89%	85.9%	90.4%
Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Hear and Treat and See & Treat

	April 23	May 23	June 23	July 23	August 23	September 23	October 23	November 23	December 23	January 24	February 24	March 24
Hear & Treat Outturn	3.5%	3.2%	4.5%	4.0%	3.4%	4.0%	3.9%	3.8%	4.4%	4.5%	5.0%	6.6%
Hear & Treat Trajectory	4.2%	4.2%	4.2%	4.4%	4.4%	4.6%	4.6%	4.6%	4.8%	4.8%	5.0%	5.2%
See & Treat Outturn	14.0%	14.4%	14.8%	14.8%	14.5%	14.4%	14.7%	14.2%	13.9%	14.5%	14.1%	13.6%
See & Treat Trajectory	14.2%	14.2%	14.2%	14.4%	14.4%	14.6%	14.6%	14.8%	14.8%	15%	15%	15.2%

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

The information below sets out the Trajectories agreed with SPPG for 2023-24 and our performance against these trajectories

Response Times

	April 23	May 23	June 23	July 23	August 23	September 23	October 23	November 23	December 23	January 24	February 24	March 24
Category 1 Mean	9mins	10mins	10mins	11mins	11mins	11mins	12mins	12mins	13 mins	13mins	12mins	12mins
Cat 1 Mean Trajectory	10mins	10mins	10mins	10mins	10mins	10mins	10mins	10mins	10mins	10mins	10mins	10mins
Category 1 90th Centile	19mins	20mins	20mins	21mins	23mins	22mins	23mins	22mins	24 mins	25mins	23mins	24mins
Cat 1 90th Centile Trajectory	21mins	21mins	21mins	21mins	21mins	21mins	21mins	21mins	21mins	21mins	21mins	21mins
Category 1T Mean	13mins	14mins	14mins	14mins	15mins	15mins	16mins	15mins	16 mins	17mins	16mins	15mins
Cat 1T Mean Trajectory	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins
Category 1T 90th Centile	26mins	27mins	29mins	27mins	32mins	28mins	31mins	28mins	32 mins	34mins	30mins	29mins
Cat 1T 90th Centile Trajectory	30mins	30mins	30mins	30mins	30mins	30mins	30mins	30mins	30mins	30mins	30mins	30mins

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

The information below sets out the Trajectories agreed with SPPG for 2023-24 and our performance against these trajectories

Response Times

	April 23	May 23	June 23	July 23	August 23	September 23	October 23	November 23	December 23	January 24	February 24	March 24
Category 2 Mean	31mins	31mins	37mins	38mins	44mins	47mins	52mins	47mins	74 mins	70mins	59mins	52mins
Cat 2 Mean Trajectory	36mins	36mins	36mins	36mins	36mins	36mins	36mins	36mins	36mins	36mins	36mins	36mins
Category 2 90th Centile	68mins	69mins	81mins	84mins	100mins	105mins	111mins	102mins	167 mins	160mins	134mins	115mins
Cat 2 90th Centile Trajectory	80mins	80mins	80mins	80mins	80mins	80mins	80mins	80mins	80mins	80mins	80mins	80mins
Category 3 90th Centile	183mins	196mins	262mins	280mins	360mins	328mins	483mins	363mins	531 mins	513mins	379mins	333mins
Cat 3 90th Centile Trajectory	233mins	233mins	233mins	233mins	233mins	233mins	233mins	233mins	233mins	233mins	233mins	233mins

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

The information below sets out the Trajectories agreed with SPPG for 2023-24 and our performance against these trajectories

Handover Performance

	April 23	May 23	June 23	July 23	August 23	September 23	October 23	November 23	December 23	January 24	February 24	March 24
<=15mins	8.8%	8.8%	8.7%	9.0%	8.3%	7.8%	7.3%	7.6%	8.1%	7.0%	7.0%	7.1%
<=15mins Trajectory	2%	4%	8%	8%	12%	15%	17%	19%	22%	25%	25%	25%
<=30mins	38.4%	36.5%	38.2%	36.1%	33.5%	33.2%	28.6%	29.3%	28.6%	26.0%	27%	28%
<=30min Trajectory	14%	14%	20%	25%	30%	35%	35%	40%	40%	45%	55%	60%
<=60mins	74.8%	76.1%	75.6%	73.1%	69.6%	69.7%	60.9%	63.5%	61.2%	56%	60.9%	61.3%
<=60mins Trajectory	59%	65%	65%	70%	70%	70%	75%	75%	80%	85%	90&	95%
>2hrs	9.2%	7.67%	9.6%	10.9%	12.7%	13.1%	20.1%	17.7%	19.8%	24.1%	18.9%	18.6%
>2hrs Trajectory	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
No of Patients >2hrs	997	881	1,040	1,206	1,371	1,334	2,090	1,821	1,992	2,345	1,758	1,894
No of Patients >2hrs Trajectory	0	0	0	0	0	0	0	0	0	0	0	0

Trust Board Finance Report

March 2024 (Month 12)

Northern Ireland Ambulance Service
Health and Social Care Trust

Contents

Executive Summary

Statutory financial performance targets **The position outlined in this report, and the associated RAG status, is subject to a number of assumptions and the completion of Final Accounts and review by External Audit.**	RAG status
Manage within allocated Revenue Resource Limit (RRL) / Achieve financial break-even	
The Trust is reporting a small surplus of £94k (0.07% of RRL) for the year ending at 31 March 2024 (Month 12).	
Manage within allocated Capital Resource Limit (CRL)	
The Trust has received a Capital Resource Limit (CRL) allocation of £13.558m. This includes allocations for Fleet & Estate, ICT, Leases, Backlog Maintenance and Medical Equipment, but excludes Research & Development. Provisional figures for expenditure at year ended 31 March 2024 (Month 12) is £13.551m against this allocation which represents an underspend against the CRL of £7k (0.05% of CRL).	
Prompt payment target-95% of suppliers within 30 days	
Cumulative performance is 96.5% for the year ending 31 March 2024 (Month 12).	

Back to Agenda

Manage within allocated Revenue Resource Limit (RRL) / Achieve financial break-even

The Trust is reporting a small surplus of £94k (0.07% of RRL) for the year ended 31 March 2024.

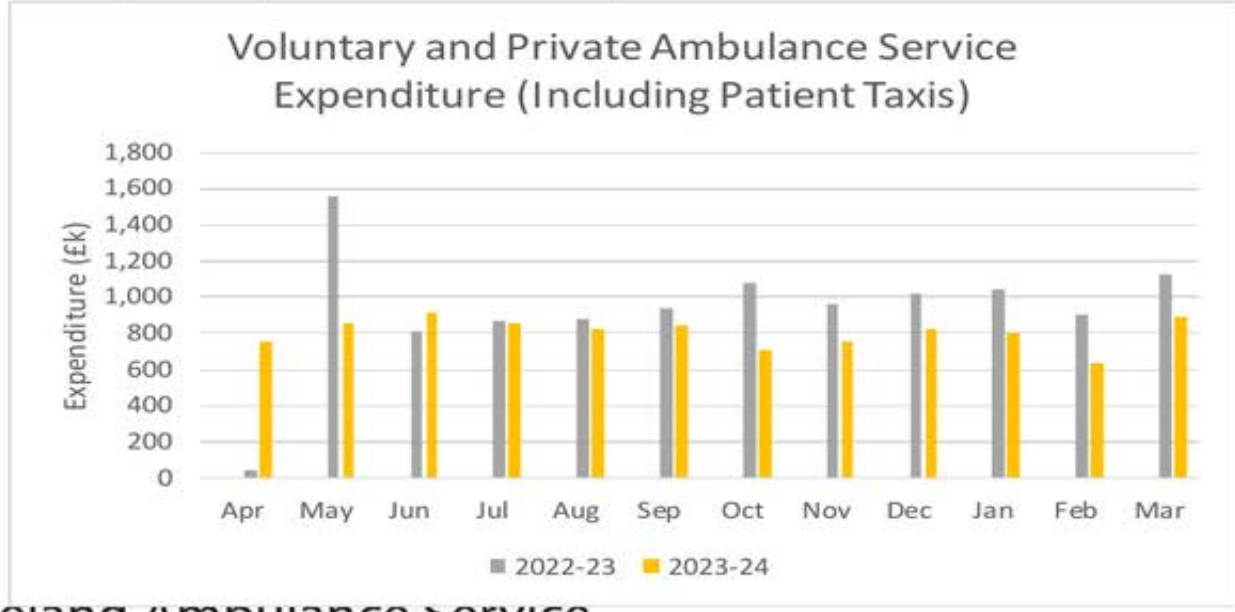
This is subject to the completion of final accounts and review by External Audit.

There are a number of assumptions and key factors underlying this position, specifically:

* Allocations - These are in line with those notified to the Trust as part of the financial planning process.
* Savings Plans – The Trust target for 2023-24 was £1.975m. This was delivered, but importantly all the proposals were non-recurrent in nature and a number are not repeatable.
* Resource Optimisation – Expenditure during the year on overtime and third party providers was managed within available resources. This had to be balanced against demand, performance and quality considerations as expenditure in these areas is lower than previous years but the service remains under significant pressure.
* Accounting Treatment – Assuming no unsupported major in year changes to accounting treatment.
* Regional financial planning for 2024-25 with Trusts and DoH/SPPG continues against a backdrop of a seriously constrained financial position across the public sector.

Voluntary & Private Ambulance Services (VAS/PAS)

- The Trust has benefited from significant additional funds as part of the response to Covid-19. This funding was applied to additional support from VAS/PAS to maintain and enhance ambulance provision during this difficult period. The Trust welcomes the support that VAS/PAS has given NIAS and HSC during this time.
- Expenditure on VAS/PAS in 2019-20 was £5.2m. Expenditure in 2020-21 was £10.1m, 2021-22 was £9.7m and 2022-23 was £9.2m. This level of expenditure was affordable given operational vacancies within the Trust and also with the additional resources provided in response to the pandemic. As the output of the training school fills vacancies, levels of expenditure should reduce. Expenditure in 2023-24 was £7.4m on IAS and £2.3m on patient taxis.
- The sustained impact of pressures across HSC has resulted in the continued reliance on VAS/PAS to maintain services. The Trust has largely been operating at the highest levels of escalation and VAS/PAS spend remains significant. In 2022-23, further costs of the order of £2.6m were also incurred for the provision of patient taxis. Monthly expenditure profiles for 2022-23 and the year to date have been updated and are shown below.

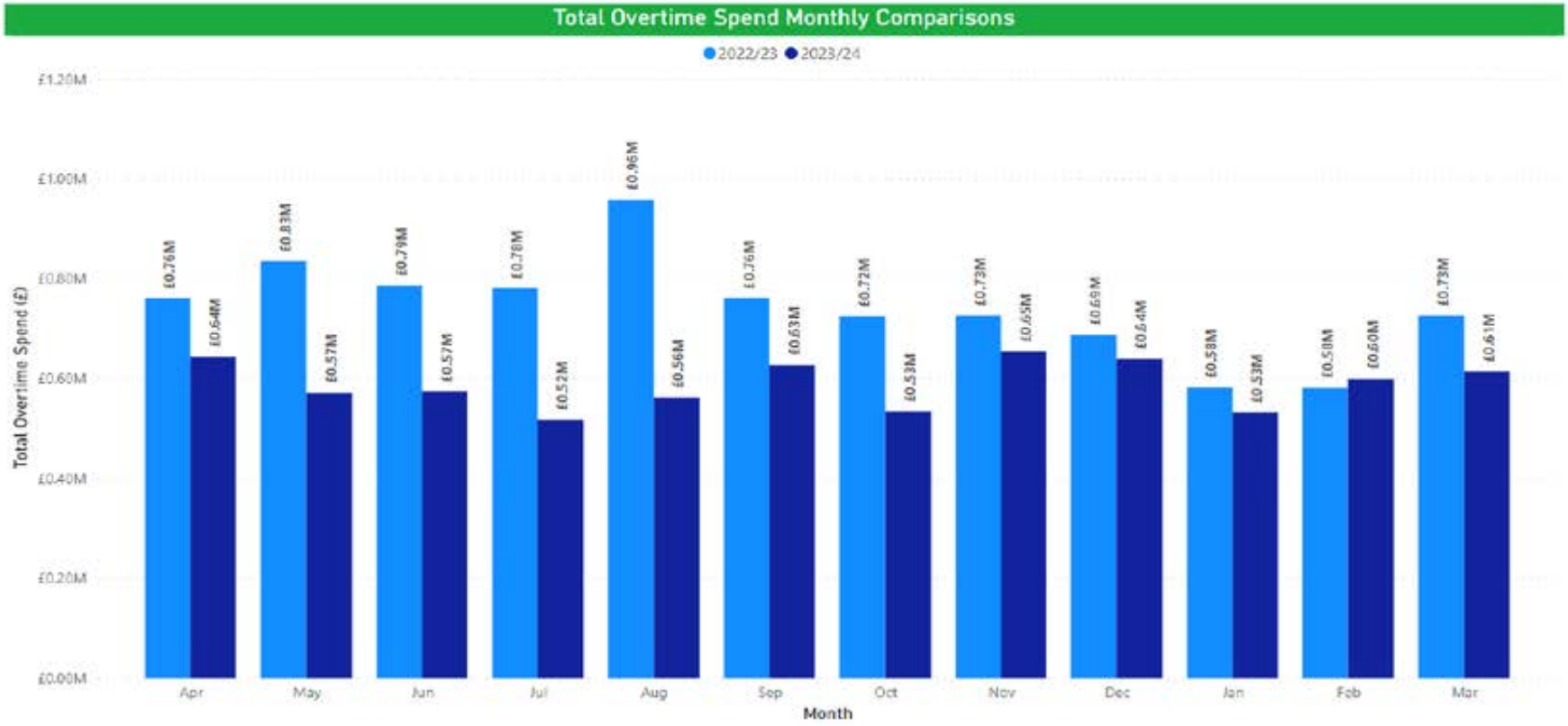


Overtime Expenditure

* The Trust relies on the use of overtime for the provision of services, predominantly for the provision of Ambulance cover. This reliance is for a number of reasons including vacancies, planned and unplanned absences and additional cover or programmes of work.
* Overtime is payable to staff in pay bands 1-7 under Agenda for Change (AfC) terms and conditions at a rate of time plus one half, with the exception of public holidays which are paid at double time.
* Overtime is paid monthly in arrears and claims should routinely be submitted within three months of the work being carried out. Staff also have the option of taking time off in lieu as an alternative to an overtime payment.
* Given the varying requirements for overtime, expenditure can vary significantly at different times in the year. This, combined with other changes between years, can mean that expenditure between years, and particularly between months between different years, may not be directly comparable.
* However, even with this variability, overall overtime has been remarkably consistent in prior years averaging circa £6m per annum. Costs in 2022-23 increased to £7.9m which was affordable with additional Covid allocations. Expenditure showed a slight downward trend for the last three months of 2022-23.
* This downward trend broadly continued for the first eight months of the 2023-24, with the exception of a slight upturns in the middle and at the end of the financial year. Costs in 2023-24 were £7.1m. This control of expenditure will need to be maintained and sustained in the future.
* The Trust has largely completed a programme of work to recruit substantively to positions that have historically been filled with overtime. There was a significant lead time for the recruitment and training of these staff. As the output of the training school fills vacancies, levels of expenditure on overtime should reduce. Levels of sickness absence are also a major driver of overtime spend.

Overtime Expenditure

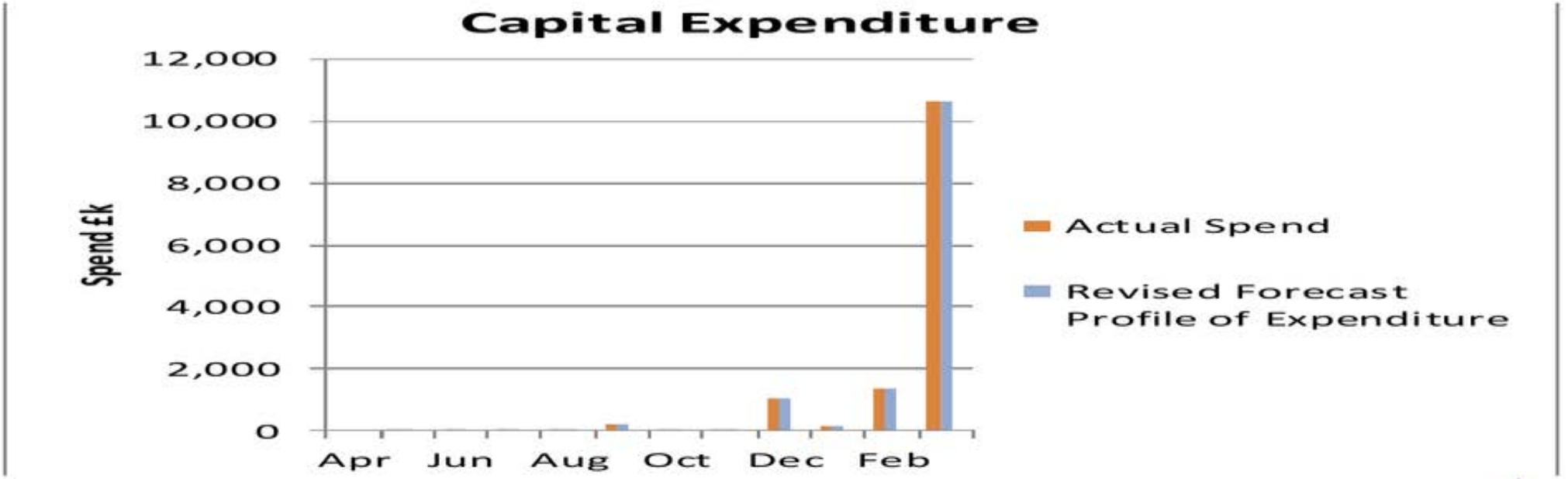
Total Overtime Spend Monthly Comparisons (£)



Manage within allocated Capital Resource Limit (CRL)

The Trust has received a Capital Resource Limit (CRL) allocation of £13.558m (previously £6.381m). This includes allocations for Fleet & Estate (£5.460m), ICT (£0.564m), Leases £0.1m and Backlog Maintenance (£0.026m). Additional funding of £7.408m has also been received for replacement medical equipment.

- Expenditure has traditionally been profiled towards the end of the financial year due to a number of factors, including business case approval, the availability of funds, procurement timescales, supplier capacity, internal capacity, project risks and lead times. Significantly, expenditure on fleet is profiled to the end of the financial year to maintain a smooth fleet age profile.
- These risks have been compounded recently due to a number of factors including EU exit, the global movement of goods, the global availability of raw materials and also associated costs of materials, production and delivery. The Trust continually reviews capital schemes to understand and mitigate against these risks.
- Provisional figures for expenditure at March 2024 (Month 12) is £13.551m against the allocation of £13.558m.



Prompt Payment of Invoices

The Trust is required to pay non HSC trade creditors in accordance with the Better Payments Practice Code and Government Accounting Rules. The target is to pay 95% of invoices within 30 calendar days of receipt of a valid invoice, or the goods and services, whichever is the latter. A further regional target to pay 70% of invoices within 10 working days (14 calendar days) has also been set.

* Performance by number of invoices paid for each of these measures is shown below. A range of measures are in place to improve and maintain performance in this area. As aged invoices are cleared and paid, performance between months can vary.

* The Trust has achieved both the 95% and 70% targets for the last three years. This level of performance has been maintained in 2023-24.

Number	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Cum	Target
Total bills paid	1,940	2,425	2,348	1,974	2,252	2,283	2,608	2,302	1,643	2,801	2,268	1,980	**26,824**	
Total bills paid within 30 calendar days of receipt of undisputed invoice	1,900	2,316	2,280	1,876	2,193	2,226	2,569	2,219	1,589	2,640	2,148	1,942	**25,898**	
% bills paid on time 30 days	97.9%	95.5%	97.1%	95.0%	97.4%	97.5%	98.5%	96.4%	96.7%	94.3%	94.7%	98.1%	96.5%	>95%
Total bills paid within 10 working days (14 calendar days)	1,745	1,629	1,854	1,621	1,919	1,858	2,087	1,790	1,395	1,514	1,684	1,465	**20,561**	
% bills paid on time 10 days	89.9%	67.2%	79.0%	82.1%	85.2%	81.4%	80.0%	77.8%	84.9%	54.1%	74.3%	74.0%	76.7%	>70%
Targets			30 days	>95%	>90%	<90%		10 days	>70%	>65%	<65%			

End of Report

Northern Ireland Ambulance Service
Health and Social Care Trust

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE PEOPLE, FINANCE AND ORGANISATIONAL DEVELOPMENT COMMITTEE HELD AT 9.30AM ON THURSDAY 29 FEBRUARY 2024 IN THE BOARDROOM, NIAS HQ

PRESENT:	Mr J Dennison	Committee Chair
	Mr P Quinn	Non-Executive Director
	Mr P Corrigan	Non-Executive Director
IN ATTENDANCE:	Ms R Byrne	Director of Operations
	Ms M Lemon	Director of Human Resources & Organisational Development (HR & OD)
	Mr P Nicholson	Director of Finance, Procurement, Fleet & Estates
	Ms L Gardner	Asst Director HR
	Ms V Cochrane	Asst Director HR
	Mr A Arandia	Asst Director Planning, Performance & Corporate Services (left the meeting at 11.30am)
	Mrs C Mooney	Board Secretary
APOLOGIES:	Mr M Bloomfield	Chief Executive
	Ms M Paterson	Director of Planning, Performance & Corporate Services

1 Apologies & Opening Remarks

The Chair welcomed Mr Quinn and Mr Corrigan to their first meeting of the Committee and said he looked forward to working with them.

2 Procedure

2.1 Declaration of Potential Conflicts of Interest

The Chair asked those present to declare any potential conflicts of interest now or as the meeting progressed.

No declarations of conflict of interest were made.

2.2 Quorum

The Chair confirmed the Committee as quorate.

2.3 Confidentiality of Information

The Chair emphasised the confidentiality of information.

3 Previous Minutes (PC29/02/24/01)

Approval of the minutes of the previous meeting held on 6 December 2023 was proposed by the Chair. However, in view of the fact that the Trust Chair had attended Committee in December, it was agreed that Mrs Mooney would seek her agreement to the minutes as seconder.

4 Matters Arising (PC29/02/23/02)

Ms Lemon explained that, in prioritising items for today's agenda, it had been agreed that the focus would be on absence and culture and advised that the rebaselined HR Plan would be deferred to the April meeting. She noted that it had been previously presented to the Committee and focused on the transformational elements of work. However, Ms Lemon said that this work had been impacted by the context of Action Short of Strike (ASOS) as well as Trade Union (TU) unwillingness to engage with the Trust on employment processes. She said that, despite this, efforts continued, where possible, to progress transformational work and any Internal Audit recommendations.

The Matters Arising were **NOTED** by the Committee.

5 **Finance Update (PC29/02/24/03)**

Mr Nicholson said he would be happy to revisit the format of the finance report to the Committee if members would find that helpful. He advised that, in the context of resource optimisation, the Trust had been focusing on variable elements of expenditure, particularly overtime and the use of Independent Ambulance Services (IAS). He referred to the Trust savings plan and said members would be aware of the need to achieve savings of £1.975 million in the 2023-24 year. He pointed out that the same extent of savings would be required in the 2024-25 year. Mr Nicholson reminded the meeting that many of the savings in the current year were of a non-recurrent nature and non-repeatable and said the Trust would have to revisit these in the 2024-25 year.

Mr Nicholson said it was now possible to produce management information in a more timely manner. He explained that the information could be produced in granular detail which would allow managers to drill down into the detail. He added that this was the first time that financial information had been made available outside the normal financial systems. Mr Nicholson acknowledged that this was not without risk and work was ongoing to ensure robust controls were in place.

Mr Nicholson drew the Committee's attention to pages 5-6 of the report which set out the management information provided and said Finance and Informatic colleagues were continually working to refine this to ensure it reconciled with information on the Trust's finance systems.

Alluding to overtime expenditure, Mr Corrigan stressed the importance of comparing like with like and noted that there had been downturn in overtime expenditure. He sought further detail on this.

Mr Nicholson explained that multiple factors were at play. He advised that Operations now targeted overtime much more effectively and staff were informed when overtime was available on particular shifts. He said that the Trust was not seeing the same uptake on overtime towards the end of the year and suggested that Action Short of Strike may also have had an impact in that staff did not wish to work overtime. However, Mr Nicholson said he believed one of the major factors was that operational staff were being

encouraged to take annual leave and when on leave, staff were not permitted to work overtime.

Mr Corrigan asked whether the core staffing complement remained consistent

Mr Nicholson advised that the Trust had filled a large number of vacancies in early 2023 and said that more staff would be recruited this year which should reduce the requirement for overtime if the Trust maintained its planned hours of cover.

Ms Byrne explained that, at the peak of the pandemic and with the uncertainty of available staff, the Trust offered overtime to staff. However, as Mr Nicholson had alluded to earlier, Operations had adopted a much more focused approach and targeted overtime.

Mr Nicholson drew the Committee's attention to page 6 of the report which provided a breakdown between Directorates and cost centres.

Mr Corrigan asked if that detailed breakdown was available to Area Managers and Station officers so they had that level of analysis to hand. He sought clarification on whether individual Divisions would be responsible for managing their respective budgets including overtime and absence management and accountability would lie with Area Managers.

Ms Byrne explained that when Assistant Directors met with the Area Managers on a 1:1 basis this information would be a standing item on their agenda to discuss any anomalies.

Mr Nicholson confirmed that accountability had been delegated to Area Managers.

Continuing his report, Mr Nicholson advised that pages 7-8 of the report provided an analysis of the use of Voluntary and Private Ambulance Services (VAS/PAS), including taxis. He advised that a new Non-Emergency Patient Transport contract had been introduced towards the end of the last calendar year which had increased providers from seven to sixteen. Mr Nicholson said that variation in expenditure between months and providers was particularly marked in the last few months as well as the use of taxis. He noted that there would be a £10 million reliance on these

two services which was only affordable through the additional allocations from the DoH linked to Covid-19. He said there was a need to pivot away from reliance on the private sector to internal service provision. Mr Nicholson noted that with the new contract providers, there was a need to ensure that the Trust received invoices and that these were appropriately validated. He added that it would take some time for the new suppliers to bed in.

Mr Quinn noted that, while there had been an increase in contractors, there had been a reduction in expenditure.

Responding, Mr Nicholson noted that an element of this was thought to be in relation to the new contract but also the fact that the focus of the Trust's financial planning in-year had been to reduce reliance on IAS. He noted the significant expenditure of £10 million.

Mr Corrigan asked whether a holistic overview was being taken of VAS/PAS across the HSC and noted that other Trusts also spent funding on PAS and taxis. He said he would be interested in seeing the trajectory of that and suggested that it would have increased over recent years.

Mr Nicholson acknowledged that this had been a particular issue in the current year and said that the system had been looking at the issue as a whole in terms of total expenditure. He said that the HSC had been engaging with the DoH to look at how transport was commissioned in that area. Mr Nicholson noted that there was often a growth in other Trusts which in turn created a demand for NIAS that was not necessarily commissioned.

Mr Corrigan expressed concern that, because NIAS' focus was on controlling spend and reducing reliance on IAS, there was potential for other Trusts to find themselves reducing services in another area in order to compensate.

Responding, Mr Nicholson acknowledged that there was potential to increase demand between Trusts if the position was not managed effectively. However, he pointed out that there were opportunities wider than the HSC to look at how transport operated across NI.

Ms Lemon alluded to the equality and human rights perspective in terms of patients' access to services across the HSC and clarified that the strategy and policy for transport was governed regionally by

the DoH's Transport Strategy. She pointed out that access to ambulance transport had to be determined by a clinician and acknowledged that this was not always necessarily the case. Ms Lemon believed there was a need for clarity at a wider level and a need for a clear strategy. She suggested that this could potentially involve public consultation as there were significant equality and human rights implications.

Mr Nicholson referred to the use of staff substitution which was covered on page 9 of the report and advised that this had markedly reduced from 2019-20 in respect of Trust expenditure on support from the Association of Ambulance Chief Executives (AACE). He pointed out that an Internal Audit recommendation had been to provide this granular level of detail to the Committee due to the levels of expenditure.

Mr Nicholson highlighted the expenditure in relation to the Regional Co-ordination Centre and reminded members that the costs associated with the staffing of the Centre from the HSC Leadership Centre would be matched by other Trusts. He said that the estimate would be in the region of £1.3 million full-year effect (FYE) with costs in the current year estimated to be in the order of £0.3 million.

Mr Nicholson noted that the Trust's Capital Resource Limit (CRL) remained largely unchanged with the vast majority of funding within Fleet & Estate. He said the report also provided some detail on the schemes currently being delivered within the Trust. He pointed out that traditionally expenditure was profiled towards the end of the year and said this was particularly challenging.

Mr Quinn acknowledged the profiling of expenditure towards the end of the year and asked whether consideration had been given to incrementally profiling the budget earlier in the year.

Responding, Mr Nicholson explained that the Trust replaced its fleet every five years. He acknowledged that the Trust was placing orders with suppliers much earlier to be assured around slots in production. He alluded to the global supply issues and said that these were impacting on the Trust with delivery times and costs being extended on several occasions. Mr Nicholson referred to the significant amount of work involved in the fleet replacement programme.

Mr Nicholson alluded to the increased requirements for business cases and said that this had had an impact. He referred to the complexity of business cases, noting that they could have both capital and revenue elements, and acknowledged the work involved in producing a summary capital plan. Mr Nicholson said the Trust's capital plan reflected the Trust's strategic direction. He reminded the meeting that the DoH would periodically request business cases as part of their annual test drilling programme.

Mr Corrigan acknowledged the time and energy invested in writing business cases and highlighted the importance of ensuring post-project evaluations (PPE) were carried out in a timely manner. He sought clarification around the assurance framework for PPE monitoring arrangements within the Trust. He asked whether the Committee received a PPE report.

Mr Nicholson acknowledged that the focus was not always on ensuring PPEs were carried out and said, while some progress had been made, it was clear that further improvement was needed. He explained that, within the Trust's Standing Orders, the Trust Board would approve capital business cases and said assurance needed to be provided to the Committee that business cases had been completed.

Mr Quinn suggested the inclusion of additional data fields to include an indication of whether a PPE had been carried out.

Mr Corrigan said that, in his previous position, the relevant Committee would have received a PPE report to provide the required level of assurance.

Mr Nicholson said that the Trust would be working towards this over the next year.

Responding to a question from the Chair as to whether such a report would be considered by the Trust's ARAC or the PFOD Committee, Mr Nicholson was of the view that the level of detail should be reported to the PFOD Committee. He reminded the meeting of the assurances provided by the test-drilling of business cases undertaken by the DoH.

Mr Corrigan suggested that Internal Audit could potentially look for evidence of PPEs having been undertaken.

Mr Nicholson agreed and noted that several Internal Audit recommendations related to the need for business cases to be developed and therefore the associated PPEs.

Concluding his report, Mr Nicholson reported that the Trust was forecasting a breakeven position within its CRL and he acknowledged the significant level of work to be taken forward between now and the end of the financial year.

Mr Corrigan welcomed the level of detail within the Finance Report presented to the Committee. He noted that the Trust was now a few weeks away from the start of a new financial year and said he expected to have had some indication of how the 2024-25 year might look.

Mr Nicholson said he intended to cover this at the March Trust Board meeting.

The Committee **NOTED** the Financial Report as presented by Mr Nicholson.

6 **HR & OD Balance Scorecard (PC29/02/24/04)**

Ms Lemon suggested there was an opportunity with new Committee members to revisit what should be included in the Scorecard. She noted that this was a work in progress and some of the reporting indicators were aspirational in nature. She thanked Mr Arandia and his team for their support in the development of the Scorecard to date.

Ms Lemon clarified that the information within the Scorecard was in-month and she acknowledged there was a slight duplication of overtime information in the context of the earlier report given by Mr Nicholson. She suggested that members may wish to consider this information remaining within the Finance report and being removed from the Scorecard.

Referring to the agency costs, Ms Lemon explained that there was an improvement trajectory in term of the use of agency staff and work was being progressed on a regional basis to reduce the overall use of agency staff. She added that this work focused largely on

reducing the use of agency nursing and said that agency usage within NIAS tended to be within A&C roles.

Ms Cochrane advised that regular meetings were held with budget holders to discuss their respective staffing positions and review any agency, acting, seconded posts with a view to reducing any reliance on this element of the workforce in the longer-term.

Ms Cochrane alluded to Key Performance Indicator (KPI) 6 'Staff Count' and explained that a significant proportion of these posts were temporary pending the outcome of restructuring, for example the Operations management structure review. She added that the Committee would not see substantive changes on a month to month basis.

Ms Lemon welcomed suggestions from members as to any narrative they would wish to see included by way of explanation around the KPIs.

Mr Corrigan asked if there were systems in place to use bank staff before overtime would be offered to staff.

Responding, Ms Byrne confirmed that bank staff would be paid at single rate and explained that the Trust's Resource Management Centre (RMC) would oversee the allocation of shifts to bank staff.

Ms Cochrane said the Trust was looking to cleanse its bank staff pool and was in the process of reviewing policies and procedures around the use of bank staff to improve governance and assurance in terms of ensuring bank staff are safe to work and maintained their clinical practice as appropriate. She added that the Committee may see a reduction in bank numbers over the coming months.

Ms Lemon alluded to the use of the term 'Whistleblowing' and said terminology such as 'Freedom to Speak Up' and 'Raising Concerns' was being used increasingly. She acknowledged that it was not necessarily a good indicator to have zero cases. Ms Lemon stressed the importance of creating a culture whereby staff felt comfortable to speak up and raise concerns. She advised that work was taking place regionally around the introduction of new policies and procedures in relation to 'Freedom to Speak Up' and 'Raising Concerns'.

Ms Gardner explained that the fact no ER cases had been closed was not an indicator that issues were not being moved forward and she confirmed that cases were being progressed as much as possible in the context of ASOS which was impacting significantly on the Trust's ability to conclude cases. She advised that she was currently reviewing the strategy to close several disciplinary cases using a more pragmatic approach. Ms Gardner said that, with the Committee's agreement, she would bring an update on ER cases to the April meeting.

Ms Lemon agreed and suggested the Committee would find it helpful to have further detail on any emerging themes and issues within the organisation.

Mr Quinn said he would find such a report helpful as the KPI did not reflect a positive position when reading the papers.

Ms Lemon said that members should not underestimate the impact ASOS had had on the Trust's ability to progress various pieces of work, internal to NIAS and also some regional work. She explained that TU representatives would only engage on those aspects of work which they considered to be concerned with the health and wellbeing of their members and said it had proved difficult on occasions to strike a balance and manage industrial relations.

Ms Lemon alluded to the regional context and pointed out that, in normal circumstances, the Trust and TU representatives would attend Joint Consultative meetings and meetings around terms and conditions. However, these had been stood down due to ASOS as TU representatives would not attend other than on issues related to pay or workforce wellbeing by exception. She said the Trust was very much committed to working in partnership with TUs and suggested it might be helpful for the Committee to receive a briefing paper around partnership working in a TU context.

Mr Corrigan said he too would welcome a more detailed position report in relation to ER cases and said he was unsure whether the numbers quoted within the Scorecard represented a positive reflection of the current position.

Ms Gardner explained that a number of the ER cases had been linked to holiday pay and pension. She advised that a further three cases had been received over the last several months and

suggested that, as the Trust was now making more difficult decisions around absence management, it was likely that there would be an increase in cases received.

Mr Corrigan acknowledged that that was an acceptable consequence of the actions required.

Ms Lemon reported that staff turnover remained static with very little change in terms of frontline staffing. She referred to the lean infrastructure with regard to support functions and said the Trust had significant reliance on several individual postholders. Ms Lemon said that, as already mentioned, a few KPIs were aspirational in nature. She said that work continued to transition the Directorate from 'process heavy' to a more customer focused function and ultimately adopt a business-partner approach in terms of working with managers and providing a service to them.

Mr Quinn queried whether staff vaccination should become a KPI and hopefully help in having an impact on short-term absence. He queried whether exit interviews would provide helpful narrative in the context of emerging themes.

Ms Lemon welcomed any suggestions and sought members' views on whether they would find it helpful to have a brief narrative included.

The Chair suggested that the narrative should be included in the cover paper by way of an executive summary which would highlight, for example, the key risks, key challenges, emerging issues and potential impact.

Responding to a question from the Chair, Ms Cochrane confirmed that the in-month absence was currently 13.60% and noted that there had been a 2% reduction in-month from December to January. She added that the cumulative figure was now 14.76% down from 14.90%.

Ms Lemon commended the huge amount of work which had been carried out across Directorates to achieve this. She said that central to this work was the recognition of the role of the manager and the fact that attendance management was an important element of that role.

Mr Quinn asked whether this information was made widely available.

Responding, Ms Lemon acknowledged that the Trust had not been proactive in terms of sharing information and said that further work was needed in this regard. She advised that she had written to every member of staff sharing the process for reporting absence due to sickness.

Mr Arandia believed that it was a journey of changing perception. He alluded to the Delivering Value programme which had been in place within the Trust over the last 8-9 months. He said that previously absence and attendance management would have been perceived as an Operations and HR issue. However, he said that staff had come together as a group of Assistant Directors, meeting on a weekly basis, and worked to develop a solution.

Ms Lemon reminded the meeting that the Chair and Chief Executive had met with her and Ms Byrne to discuss the Board's concerns around attendance management. She said that, following that meeting, enhanced accountability arrangements had been put in place and the Trust Chief Executive held each Director accountable for absence within their respective Directorates. Ms Lemon added that she and Ms Byrne met on a weekly basis while the Chief Executive met with her and Ms Byrne on a monthly basis and said that Ms Charlton now attended these meetings in the context of Patient Care Services.

The Committee **NOTED** the HR&OD Balance Scorecard as had been presented by Ms Lemon and colleagues.

7 **Maximising Attendance:**
- Progress Report
- Delivery Plan Update (PC29/02/24/05)

Ms Lemon and Ms Byrne described the nature of their weekly meetings and said these focused on identifying particular outliers with a view to determining the most appropriate performance management approach.

Ms Byrne said that the level of granular detail and identifying hotspots had been key to making progress.

Ms Lemon commented that the culture which the Trust aspired to was to have managers engaging with individuals on a regional basis. She acknowledged the importance of assurance but was of the view that further work required to ensure robust arrangements were in place.

Ms Byrne noted that the highest priority for her was the Operations restructure and the need for a 24/7 robust operational management cover. She explained that, having this in place, would support the attendance management process.

Ms Lemon acknowledged that, while the initial priority had been a focus on long-term absence, the importance of the management of short-term absence remained critical, in particular where a pattern might exist.

Referring to the medical redeployment process, Ms Cochrane said that previously the Trust had approximately ten redeployments each year. However, in 2023, the Trust had between 30-40 members of staff to be redeployed. She said there was an expectation amongst staff that it would be possible to redeploy to another role as they have seen roles being created across Directorates. Ms Cochrane pointed out that the majority of staff awaiting redeployment were Emergency Medical Technicians (EMTs) and paramedics and she acknowledged the challenges in identifying suitable redeployment opportunities for staff within the Trust.

Ms Gardner pointed out that the Trust had engaged with Trade Unions around applying a more timebound process for the management of employees who had been determined to be suitable for medical redeployment. This would include application of communication of an 8-week window for consideration of potential redeployment options.

Mr Quinn queried whether there had been an increase in Industrial Tribunal cases as a result of redeployment decisions.

Ms Lemon explained that there were a number of grievance cases around disability discrimination and some of these were translating into Labour Relations Agency/Tribunal processes.

Ms Byrne referred to the impact on service delivery. She explained that, historically, EMTs and paramedics would have been

redeployed to the Clinical Support Desk but on some occasions, individuals were unable to work nights.

Ms Lemon acknowledged the challenging circumstances in which staff worked and highlighted the Trust's duty of care to them. She suggested it might be helpful to bring to a future meeting of the Committee an update in relation to the provision of peer support services. She said it would be important when discussing redeployment to be mindful that, in many cases, these staff had had exposure to extreme trauma.

Mr Corrigan said that his overall observation around attendance management was that positive steps were being taken and he hoped the Trust was now starting to see the benefits of that work. He said he remained to be convinced that the Trust had seen the start of a cultural shift and believed that further work was needed to ensure absence was 'front and central' throughout the Trust. Mr Corrigan stressed the importance of ensuring a shift in culture at every level to the point that managing absence became everyone's responsibility.

Mr Quinn believed it was important to bear in mind that there were other cultural issues to be addressed. He alluded in particular to the fact that there was no specific reference within the HR Delivery Plan to the vaccination programme and queried whether it should be included as the paper focused on a health and wellbeing approach. Mr Quinn also asked if the Trust had evaluated the mental health services it commissioned.

Ms Lemon agreed that it would be provide an update to a future meeting addressing these points.

The Chair welcomed the RAG rating of the Delivery Plan, in particular the number of amber ratings and noted that the due dates against many objectives were imminent. He sought clarification on whether those objectives which had been RAG rated as red would impact more significantly on the Trust's managing attendance plans.

In response, Ms Lemon said that the intention was for the Committee to see more green RAG ratings and she cited the example of an analysis of mental-health related absence. She said she hoped that the work being undertaken around redeployments would result in an improved position. Ms Lemon explained that

some of the work required was similar to that of Internal Audit in that evidence was required to support the work. She added that this would be key in achieving the objectives by the end of March.

The Chair thanked Ms Lemon for the update which was **NOTED** by the Committee.

8 **HR Assurance Framework – working draft (PC29/02/24/06)**

Ms Lemon drew the Committee's attention to the working draft of the HR Assurance Framework which aimed to provide members with a sense of the direction of travel. She explained that this had been very much based on the Board Assurance Framework and said the intention was for each Directorate to have an Assurance Framework.

Ms Cochrane advised that the document focused on the Directorate's core business as usual objectives across key functions which were key to the delivery of HR&OD but also setting out how these would be proactively evidenced and assurance provided. She explained that further development of the Framework would inform a refresh of the Directorate's Risk Register to ensure a comprehensive overview of risks throughout the Directorate.

The Chair welcomed the linkages to the Corporate Risk Register and said he was aware of the intention to undertake a review of the Corporate Risk Register. He acknowledged the working draft nature of the document and asked how the Committee could assist in progressing this work.

Ms Lemon said she would welcome a steer from the Committee as to whether the document reflected an appropriate direction of travel, approach and methodology. She said that she was seeking to be transparent and recognised that some of the work would need to be progressed within an improvement space.

Mr Quinn commended how the Assurance Framework had been set out and said he would be minded not to include culture on the Framework. He suggested that there could also be 'softer' elements which should be included.

Ms Cochrane, agreeing, said that there would also be elements which were more strategic in nature, for example, culture, OD and health and wellbeing.

Mr Corrigan believed that the document was a helpful starting point and would assist the Committee in identifying those issues which required closer attention.

Ms Lemon said the document would also help in identifying those issues to be presented to the Committee to provide assurance.

The Chair acknowledged that the document was work in progress and highlighted the need for high level points, identifying the risks and challenges to delivery and ensuring its purpose was not lost in the detail.

The Committee **NOTED** the HR Assurance Framework (working draft).

9 **Organisational Culture**

Ms Lemon undertook to share with members the 'Culture Review of Ambulance Trusts'.

Mr Corrigan asked whether a Personal Development Review (PDR) process was in place for clinical staff.

Responding, Ms Lemon explained that this had been within a project space and related initial testing of a new model had been undertaken within a small staff group.

Ms Byrne advised that the development of clinical staff was supported by the Clinical Training Team and staff were required to develop portfolios as part of their ongoing clinical supervision.

Ms Lemon was of the view that the work being taken forward in relation to culture provided an opportunity to redesign roles and expectations of managers and ensure value-based recruitment.

Mr Corrigan acknowledged that the Trust was on a journey and said that the Committee would be keen to support this work. He sought an update in relation to the Operations restructure.

Ms Byrne said it would be helpful to provide an update to the Committee on this work and undertook to confirm arrangements for doing so.

Mr Quinn suggested that Non-Executive Directors had a key role to play in the delivery of an improved culture within the organisation. He acknowledged the work which had been done to date and highlighted the need to take account of external stakeholders as well as internal stakeholders. Mr Quinn said that, since his appointment as a Non-Executive Director, he had been aware of the central role NIAS played in the HSC system. He alluded to NIAS culture in terms of the wider HSC but also how the Trust was perceived and how culture inevitably impacted that particular narrative. Mr Quinn suggested that the Trust was at risk of losing how service users perceived the organisation as a result of the delayed handovers. He added that the other stakeholders were Trade Unions. He referred to the results of the wider HSC staff survey but suggested that a more bespoke survey should be undertaken with NIAS staff, looking at NIAS values and how aligned they were.

Mr Quinn alluded to FREDA – freedom, respect, equality, dignity and autonomy – and said that, while the Trust worked to treat patients like this, it would also be important to treat staff similarly. He commended the QI approach within the Trust and the approach to just culture, encouraging staff to speak up.

Mr Quinn believed that the Review of Clinical Education had the potential to act as a capacity framework as well as overseeing the development of an appraisal process.

In terms of leadership visibility, Mr Quinn suggested that there needed to be a clear internal communications strategy around this and acknowledged the benefits of technology to assist with this.

Ms Lemon said she was hoping to establish a cross-Directorate group to consider matters of culture and invited Mr Quinn to be involved in this work.

Mr Quinn confirmed that he would be happy to participate.

The Chair thanked members for the comments and the update on culture was **NOTED** by the Committee.

10 **Reflection on away day – OD aspects**

It was noted that this item had been covered in earlier discussion.

Ms Lemon noted that the report from the Strategic Planning away day would be shared with members in due course.

11 **Date of next meeting**

The next meeting of the Committee is scheduled to take place on Thursday 18 April 2024 at 9.30am in the Boardroom, NIAS HQ.

12 **Any Other Business**

(i) HR&OD Structure

Ms Lemon provided an update in relation to the HR&OD structure.

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED AT 12.30PM.

SIGNED: _____

DATE: 18 April 2024

Northern Ireland Ambulance Service
Health and Social Care Trust

'PEOPLE' COMMITTEE REPORT TO TRUST BOARD 9/5/24

The People, Finance and Organisational Development Committee met on Thursday 18 April 2024.

Issues discussed included:

1	**Financial Plan 2024-25** The Committee received a briefing from the Trust's Director of Finance on the approach that will be taken by the Trust in the development of its 2024-25 Financial Plan. The Committee enquired about the status and plan for the 2023-24 final accounts, the Director of finance outlined that they were being prepared and would be brought to the Board meeting scheduled for 9 May 2024.
2	**HR & OD Balance Scorecard** The Committee noted the Key Performance Indicators reported and agreed that it would now be timely to review the content of the Scorecard with a view to determining what indicators members would like to have reported.
3	**HR & OD Improvement Plan – April 2024** The Committee noted that, while work to progress the Improvement Plan had been paused due to industrial action and the prioritisation of workstreams associated with the Delivering Value Programme, it was anticipated that, in transitioning from Action Short of Strike, work would now recommence with a focus on prioritised initiatives.
4	**Maximising Attendance Progress Report & Delivery Plan** The Director of HR & OD presented a report detailing progress around the Maximising Attendance project, including Trust performance against the DoH target. The Committee welcomed the total in-month absence percentage for February 2024 of 12.08% with a cumulative absence of 14.54%.

5	**Update on Peer Support and Health and Wellbeing Workstreams** The Committee received an update from Ms Ann Marie McStocker on year two of the Trust's Health and Wellbeing Strategy 'Healthy People, Healthy Place' which was approved by the Board in August 2022. Ms McStocker was joined by Ms Emma Hallissey, Health and Wellbeing and Peer Support Lead, and Ms Valerie O'Neill, Health and Wellbeing and Peer Support Officer.
6	**Further updates** In addition, updates were provided on: • Operations Directorate restructuring; • Employee relations cases and policy development; • Organisational culture development.

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE SAFETY, QUALITY, PATIENT EXPERIENCE AND PERFORMANCE COMMITTEE HELD AT 9.30AM ON THURSDAY 25 JANUARY 2024 IN THE BOARDROOM, NIAS HQ

PRESENT:	Mr D Ashford	-	Committee Chair
	Mr P Quinn	-	Non-Executive Director
	Dr P Graham	-	Non-Executive Director
IN ATTENDANCE:	Mr M Bloomfield	-	Chief Executive
	Ms R Byrne	-	Director of Operations
	Ms L Charlton	-	Director of Quality, Safety & Improvement
	Mr P Nicholson	-	Director of Finance, Procurement, Fleet & Estates
	Ms M Paterson	-	Director of Planning, Performance & Corporate Services
	Mr N Sinclair	-	Chief Paramedic Officer
	Mr R Sowney	-	Senior Clinical Adviser
	Mrs C Mooney	-	Board Secretary
	Ms R Finn	-	Assistant Director QSI
	Mr P Corns	-	Consultant Paramedic (for agenda item 6 only)
	Mr T O'Neill	-	Education Team (for agenda item 6 only)
APOLOGIES:	Dr N Ruddell	-	Medical Director
	Ms M Lemon	-	Director of HR & OD

1 Apologies & Opening Remarks

The apologies were noted.

The Chair welcomed members to today's meeting, particularly the new Non-Executive Director members of the Committee, Mr Quinn and Dr Graham.

2 Procedure

2.1 Declaration of Potential Conflicts of Interest

There were no declaration of conflicts of interest.

2.2 Quorum

The Chair confirmed that the Committee was quorate.

2.3 Confidentiality of Information

The Chair emphasised the confidentiality of information.

3 Previous Minutes (SC25/01/24/01)

The minutes of the previous meeting on 17 November 2023 were **APPROVED** on a proposal from the Committee Chair and seconded by Mr Bloomfield.

4 Matters Arising (SC25/01/24/02)

Members **NOTED** the actions taken against the Matters Arising.

(i) Hand Hygiene Standards

Ms Finn updated the feedback to Committee on engagement with national IPC colleagues around Hand Hygiene standards and explained that the Trust had wished to consider if the hand hygiene target was too ambitious at 90%. However, she said, having engaged nationally in this regard, the team had concluded that the target of 90% was reasonable and Ms Finn highlighted that NIAS was not currently achieving this compliance despite a number of actions within the Trust to improve.

The Chair stressed the need for the Trust to renew its efforts to encourage staff to adhere to the guidelines.

(ii) FIT Testing

Ms Paterson reminded members of the discussion at the previous Committee meeting in November when she had advised that 1,186 staff were required to be FIT tested. She explained that all staff had

been FIT tested at the start of the pandemic, with all testing expiring at the same time. She advised that a plan on how this would be addressed by the end of March was currently in development but acknowledged that it would be important for the Trust to put more robust and resilient arrangements in place moving forward.

Mr Nicholson explained that there were two elements to this issue. Firstly, the testing exercise itself and secondly the release of staff to be tested for the different types of masks that were available.

(iii) Body Worn Video (BWV)

Ms Paterson alluded to discussion at the November meeting on the 2022-23 Annual Health, Safety and Fire Safety Annual Report and the queries over whether there had been a reduction in the number of assaults against staff through the use of Body Worn Video (BWV). She advised that, since the full introduction of BWV in April 2023, the Trust had not seen a decrease in the number of incidents of violence and aggression reported by staff. She pointed out that, while there had been a slight decrease in the number of reports for 2022-23, there had been an increase in reports in quarter three.

Ms Paterson reported that the project had been fully rolled out to operational staff, with 420 cameras available across 34 sites. She advised that camera use was gradually increasing with an average of 55 cameras being carried per shift. However, she said, this only represented approximately 25% compliance. Ms Paterson indicated that there still appeared to be a reluctance by staff to use cameras and added that anecdotal feedback showed that staff were apprehensive that the BWV would be used to oversee clinical practice.

Mr Bloomfield pointed out that the use of BWV by staff was voluntary. He commented that, at the time of introducing the BWV, it had been hoped that seeing the positive benefits would encourage staff to use BWV. Mr Bloomfield noted that there was some national consultation ongoing around the use of BWV and he queried whether there was any learning for the Trust from the consultation with a view to increasing uptake amongst staff.

Ms Paterson advised that NIAS was hosting the National Violence and Aggression Team in Belfast on 6-7 February and said the team

would liaise with the Team to ensure the Trust was establishing best practice and exploring every option to do so.

Responding to a question from the Chair on whether there was any potential for BWV to be used to oversee clinical practice, Mr Bloomfield explained that the incidences in which BWV could be used were very tightly controlled, ie only for use in potential incidences of violence or aggression against staff.

Ms Paterson alluded to the detailed discussion which had taken place at ARAC in the context of the information governance aspects of the Policy. She said the Policy made it very clear that the use of BWV was for the protection of NIAS staff.

Mr Quinn referred to the anecdotal feedback and suggested the use of questionnaires to collate feedback might be beneficial.

Ms Paterson said that the fact the Trust was now seeing a reduction in the use of BWV would signal that it needed to undertake further engagement with staff to determine, for example, if further training was required. She said it would be important to capture such issues in a qualitative way to inform the next steps. Ms Paterson reminded colleagues of the significant investment in the procurement of BWV equipment and said the Trust was able to demonstrate that the use of BWV reduced the escalation in certain situations when it was made clear that the equipment was being used. She said it was fair to say that the majority of staff who reported assaults/acts of aggression had not been wearing BWV at the time of the incident and that few of the reported assaults had been recorded. Ms Paterson said that the Trust had forwarded footage to the PSNI to support prosecutions but unfortunately the Trust was not yet notified by the PSNI of successful prosecutions.

The Chair thanked Ms Paterson for her update and suggested that the Committee should receive a further update in six months' time. Ms Paterson agreed to take forward as appropriate.

(iv) Emergency Preparedness, Resilience and Response

The Chair noted the continuing progress in relation to EPRR and said he looked forward to further updates.

5 **Standing Items:**

(i) **Identification of Risk**

The Chair explained the background to this particular agenda item.

Mr Quinn said he would find it useful to have sight of the existing risks for the Committee in order to create a baseline. Ms Charlton said she would be happy to look at this and circulate as appropriate.

In terms of identifying risk for the Committee, Ms Charlton alluded to the low uptake of the flu and Covid-19 vaccinations amongst staff. She explained that, over the last couple of years, the Trust had not been able to administer the vaccines within the Trust due to storage requirements. She added that the PHA had worked with the Trust to deliver a vaccination programme and ensure access for staff to receive their vaccinations at other Trust vaccination centres.

Ms Charlton reported that the flu vaccination uptake was 21% regionally with NIAS at 12%, while the Covid-19 vaccination uptake was at 16% regionally, with NIAS at 9%. She acknowledged that there had been a much lower uptake rate across the region than in previous years and the PHA had expressed some concern at this.

Continuing, Ms Charlton said it had originally been thought that the vaccination programmes would end in December. However, the Trust had been advised that these would now continue until the end of March. She said the Trust had engaged with PHA colleagues and were exploring internally how the Trust might make a more concerted effort and revert to a peer delivered vaccination programme until the end of March. Ms Charlton said the Trust had also engaged with national colleagues to determine if this was a risk reflected on corporate risk registers and feedback to date indicated that it was not. She added that feedback through IPC colleagues had also shown that the low uptake rate had not been reflected as a risk on HSC registers. Ms Charlton said she was of the view that the low level of uptake should be identified as a risk on the Corporate Risk Register and wanted to bring this to the Committee's attention. She pointed out that, regardless of the concerted efforts made over the next number of weeks, regrettably the Trust would not achieve its previous vaccination levels.

Mr Sowney sought further detail on the proposed arrangements.

Responding, Ms Charlton advised that she and the IPC team were engaging with Mr Sinclair's team around the pharmacy input required. She explained that the vaccination programme would require two paramedics and work was underway to explore the potential of using paramedics currently on light duties. Ms Charlton said that the Senior Management Team (SMT) had felt it was important to make every effort to increase the uptake levels amongst staff.

Ms Byrne commented that the reduction in the vaccination levels reflected the downturn seen by primary care colleagues in the public not receiving both vaccinations.

Mr Sowney commented on the pharmaceutical input required and alluded to the pressures within the small team and asked whether the Trust's plans to have its own vaccination programme were realistic.

Ms Charlton said that SMT had discussed how much pharmaceutical input would be required and whether this would be detrimental to their workplan. She advised that the time requirement would be two weeks and said that, given the workplan and the risk to the delivery of that workplan, SMT had collectively agreed that the Trust should proceed to have an internal vaccination programme until the end of March.

Ms Charlton pointed out that NIAS did not have a 'flu team' as such and had not been funded by the PHA for its administration of the vaccine through internal arrangements. She referred to the operational pressures which had existed recently and said these had also contributed to the low uptake levels amongst staff. Ms Charlton said that the PHA was now considering a funding stream for the Trust for future programmes and added that it would be important that the Trust would consider putting more robust arrangements in place for future vaccination programmes should the necessary funding be made available.

Mr Bloomfield believed that the low uptake rates were more of a societal issue. He said that, for a number of years, NIAS had achieved the highest uptake rates across the HSC and had been lauded by the Chief Medical Officer on many occasions.

Mr Quinn said that he was shocked at the low uptake rates across the HSC and agreed that it would be important for the Trust to act. He believed that it was as much testing the impact now so as to gauge future impact. Mr Quinn alluded to the mixed messaging and cited the example of 60-65 year olds not being eligible to receive the flu vaccination while individuals who were 50+ years were eligible to receive the Covid-19 vaccination.

Mr Sowney agreed that there was an element of mixed messaging.

6 **Occupational Road Risk & Fleet Safety Policy v1.0 Driving and Care of Vehicles when driving on behalf of the Trust v11.4 (SC25/01/24/03)**

The Chair welcomed Mr Corns and Mr O'Neill to the meeting and asked them to present the 'Occupational Road Risk & Fleet Safety Policy v1.0' and the 'Driving and Care of Vehicles when driving on behalf of the Trust Standard Operating Procedure (SOP)'.

The Chair welcomed the development of the Policy and said it was not dissimilar to other emergency services road operational policies.

Mr Bloomfield explained that the Trust had developed this Policy in the knowledge that it would be introduced at risk. He acknowledged that he was uncomfortable with seeking Committee approval to a Policy which he knew the Trust would experience challenges in implementing. However, he stressed that the Senior Management Team's strong view had been that having the Policy was the right thing to do and that the Trust could focus on working towards full implementation of the Policy. Mr Bloomfield indicated that, if it were not possible to provide the capacity from within the Trust's own training team, assistance would be sourced from external providers. However, he added that he was of the view that, over time, having internal capacity would be important.

The Chair commented that the Trust was now committing to paper what should be done in relation to these areas of work.

Agreeing, Mr Bloomfield reiterated that the development of the Policy was the right thing to do. He clarified that it not only concerned NIAS staff but also the Voluntary Car Service and anyone who drove on behalf of the Trust.

Ms Paterson pointed out that the benefits of having the Policy outweighed the risk carried by the Trust and clarified that the assessment element of the Policy was where the risk lay. She said the Trust would work to implement the Policy in the knowledge that there would be elements within it which would not be implemented satisfactorily.

Mr Corns pointed out that, although the Trust would be unable to carry out the 250 assessments required, it would be able to process approximately 100 assessments per year. He drew the Committee's attention to the risk assessment tool at the back of the Policy which would be used to prioritise staff for assessment.

Responding to a query from the Chair, Mr Corns confirmed that the 250 assessments would include assessments in respect of voluntary car drivers. He clarified that the Trust had approximately 1,100 operational staff and around 80-100 'grey fleet' which, for example, were voluntary care drivers and Community First Responders.

The Chair questioned the timeframe for assessment of competency being between every three to five years.

Mr Corns explained that five years was the legal requirement and explained that the Policy had been developed in conjunction with the National Driver Training Advisory Group. He acknowledged that other services had opted for assessment every three years and said that it was accepted that assessment between every three to five years was in order.

Mr O'Neill pointed out that five years would be the maximum timeframe. He acknowledged that some staff had been in the service for a number of years and would be viewed as priority for assessment. However, those Associate Ambulance Practitioners (AAPs) due to qualify in April would not be due for assessment until 2029. Mr O'Neill referred to the rolling process of assessment.

The Chair welcomed the prioritisation approach. He referred to red traffic light signals and said that his understanding was that the legislation allowed this to be treated as give way in an emergency situation.

Mr O'Neill noted that, in driver training, a red traffic light signal was either a stop or give way signal.

The Chair asked whether consideration had ever been given to 'black box' technology for routine calls.

Mr O'Neill explained that, if ambulances exceeded the speed limit on non-emergency calls, a voice warning sounded in the cab. However, this ceased when lights and sirens were activated. He added that there was technology on the vehicles which recorded the vehicle speed throughout each call.

Mr Sinclair added that the technology also recorded the times at which blue lights were deployed and the volume etc.

Mr Corns alluded to the table on page 15 of the SOP which set out the statutory speed limit and the NIAS guidance limit and stressed that the speeds were not targets or expectations. He emphasised the importance of taking account of road conditions.

Mr Sowney referred to the need to undertake basic roadworthiness checks and asked how realistic it was to expect staff to undertake these even when being dispatched to a Cat 1 call. He acknowledged that a basic inspection would take a couple of minutes approximately and alluded to the impact on the response time of 8 minutes for a Cat 1 call.

Mr Corns acknowledged the negative impact on such calls but said it was important that the Trust provided the appropriate guidance to staff. He referred to the constant dispatching of vehicles and said it was unlikely that full Vehicle Daily Inspections (VDI) were carried out. However, he said, this did not mean that the Trust should not recommend it and support staff to do so. Mr Corns added that some staff came on shift early to carry out a VDI, however he added that this was an individual's choice.

Mr O'Neill commented that it was practice to advice Control if unable to conduct a VDI.

Mr Sowney pointed to para 1.13.3 re the use of the MDT screen and the fact that it '… must not be used by the driver whilst the vehicle is in motion ….'. He said that the Trust had been encouraging its use and now appeared to be reversing on this approach.

Mr Corns acknowledged that the vast majority of MDT usage would be by the attendant as would usage of a mobile phone. He cited the example of being a single-handed practitioner in a RRV vehicle and said that using a MDT whilst responding to an emergency call was extremely challenging.

Ms Paterson agreed that staff should only be using the MDT screen when it was safe to do so.

Mr Sowney referred to para 4.9 of the Policy around 'Fatigue' and questioned how this impacted on staff given the challenges around missed meal breaks. He also queried whether there was provision within the guidance to encourage staff to report fatigue and to be stood down for a period of time if deemed appropriate. Mr Sowney accepted the importance of acknowledging fatigue and felt it would be important for staff to report fatigue. He said he was of the view that it would be difficult for consideration to be taken of this given the current pressures.

Mr O'Neill said the Trust would encourage rotational driving and alluded to the setting up of welfare hubs at EDs. However, he acknowledged that the Trust attempted to encourage staff to self-report fatigue.

Mr Sowney alluded to those circumstances where staff experienced fatigue not only on shift but on driving back to station. He said the Trust had a duty of care to staff and acknowledged the complexity of such issues.

Ms Byrne referred to the work being taken forward by the Trust in relation to late finishes and missed meal breaks and acknowledged that, whilst not dramatic, there had been a slight improvement in the position.

Ms Charlton said that, over the last number of months, the Trust had made concerted efforts to relieve crews at EDs at the first possible opportunity in order to avoid protracted shifts of 15-16 hours.

Mr Sowney was of the view that the Trust should not be using these staff as an additional resource when they finished their shift.

Mr Nicholson highlighted the two elements to driver training. The first element was around having the necessary infrastructure and vehicles to deliver the training and the second related to the ability of the Trust to release staff to undertake the training.

The Chair acknowledged his nervousness in the Committee approving a Policy which the Trust clearly would struggle to implement fully. He expressed concern at the potential for the 100 assessments which could currently be undertaken to become the norm as opposed to striving to deliver 250 assessments per year.

Mr Sinclair advised that there was a business case developed to support the Trust requirements to implement the Policy.

Mr Bloomfield said he understood the Chair's concerns and believed that having a Policy highlighted the gaps within the Trust and the need for a plan to address such gaps. He suggested that the Committee might wish to approve the Policy and SOP reflecting the Committee's clear concerns around the Trust's ability to implement the Policy and SOP and that it wished to review the position in six months' time.

Mr Quinn agreed with the suggestion put forward by Mr Bloomfield and believed that the Trust could not countenance the continuation of not having a Policy and SOP in place. He acknowledged the challenges associated with implementation. Mr Quinn proposed that the implementation plan should set out incremental interim projections of performance against the Policy to ensure the Trust continued to strive to meet its targeted assessments.

Mr Bloomfield clarified that the Trust provided driver training to the Ulster University graduates and that emergency driving was not part of the degree course.

Ms Paterson suggested that a phased implementation plan should be scrutinised by the Committee.

Mr Quinn commented on the length of the Policy and believed that there were elements of a SOP within it. He suggested that, on occasions, policies were more accessible if brief and concise.

Ms Paterson alluded to the extant framework in place and said there would be an opportunity to look at this moving forward.

Following discussion, Mr Quinn proposed that the Committee approve the Policy and SOP. This proposal was seconded by Dr Graham and **APPROVED** by the Committee with the caveat that the position would be reviewed in six months' time and that a phased implementation Plan would be presented to the Committee showing a clear trajectory to achieve the target of 250 assessments per year.

The Chair thanked Mr Corns and Mr O'Neill for their attendance and they withdrew from the meeting.

7 **NIAS Annual Pharmacy Update (SC25/01/24/04)**

The Chair welcomed Ms Catherine Hanna to the meeting and invited her to present her update.

Following Ms Hanna's presentation, the Chair commended her for her leadership and the significant progress which had been made since she had joined the Trust. He reminded the Committee that the Trust had previously not had any pharmacy oversight.

However, he alluded to the current arrangements whereby pharmacy teams members had been seconded to NIAS and expressed concern at the potential cessation of this arrangement.

Mr Bloomfield acknowledged the significant progress which had been made and noted that, of the 131 actions recommended by the Medicines Regulator, the Trust had completed 123 with only eight outstanding. However, he noted the significant risks associated with the outstanding actions.

Continuing, Mr Bloomfield referred to the seconded posts within the pharmacy team and said the Trust was trying to assess the scale of the pharmacy requirement within the Trust as work to address the Medicine Regulator actions progressed. He acknowledged that it was an area where the Trust had to assess the level of risk against the financial risk.

Mr Sowney alluded to the level of work yet to be completed in terms of policies, procedures and legal documentation. Ms Hanna acknowledged the challenges associated with the timeframe for completion of the actions and said the focus was now on completion by the end of March.

She acknowledged that further work was required to improve Patient Group Directive (PGD) record keeping and said she had engaged with the education team with a view to disseminating learning through learning letters and speaking to staff.

Mr Sowney noted that over one third of inspections undertaken by the Medicines Regulator had been within NIAS.

Ms Hanna confirmed that this was the case and indicated that the Trust had not been fully inspected since 2012 despite requests from the Medical Director to the Medicines Regulator. However, she acknowledged that, should the Trust not be in a position to complete the actions and demonstrate improvement in relation to the management of controlled drugs, there was potential for the Regulator to undertake a full inspection. She pointed out that inspections were undertaken on an annual basis within the English model.

Ms Hanna said that the Trust's Medical Gas Group had not yet been established and explained that the Group would consider the risks associated with medical gases and the need for more robust governance procedures.

Mr Nicholson pointed out that the Trust had a Medical Equipment Group which would consider medical gases and accepted that the Regulator's actions provided an opportunity to reconsider how this was managed.

Ms Hanna acknowledged this but advised that there was no specific group meeting on a monthly basis to manage this equipment.

Mr Sinclair explained that, through the work completed by Ms Hanna and her team, the Trust had been able to identify a number of issues to be examined in further detail.

Mr Sowney welcomed the fact that issues were being identified for further consideration.

Ms Hanna advised that work was ongoing to develop a pharmacy dashboard which would show, for example, usages of morphine by staff and allow the Trust to identify above normal levels of drug usage.

The Chair referred to a time when the Trust did not have a Pharmacy Lead and he commended Ms Hanna on the progress she had made to date. He acknowledged the importance of completing work over the next few months.

Mr Quinn said that Ms Hanna's presentation highlighted the risks associated with medicines management within the Trust.

Ms Charlton agreed and believed it also assisted in clarifying the risks from the Committee's perspective.

Ms Paterson clarified that, while the Trust's Audit and Risk Assurance Committee had a number of risks which fell within its remit, it was ultimately responsible for the governance of risks with individual Committees overseeing the mitigation and actions taken to reduce the level of risk.

Mr Sowney asked for the inspection reports to be shared with members. Ms Hanna undertook to forward these to Mrs Mooney for onward circulation to the Committee.

Mr Quinn said he had found it interesting, coming from a regulatory background, that the regulator had undertaken 33 inspections within one organisation.

Ms Charlton reminded the meeting that the Trust had not been fully inspected since 2012 and said that a large proportion of the issues had been historic to the Trust in the context of not having similar inspection programmes or a similar infrastructure to other Trusts. She welcomed the attention given by the Regulator as the Trust strived to improve its governance in this area.

Mr Bloomfield explained that the Trust had decided to recruit at risk in areas such as pharmacy, safeguarding, Public and Personal Involvement (PPI) and Infection Prevention Control (IPC) for example and he acknowledged that current size of the pharmacy team was inadequate for the Trust. However, he said it had been made clear to the Trust that if it believed there were areas of such significant risk, the Trust would have to identify funding from within its existing resources to address the gap.

The Chair said it was incumbent upon the Trust's Non-Executive Directors to highlight these challenges at every opportunity.

He thanked Ms Hanna for her annual pharmacy update which was **NOTED** by the Committee and Ms Hanna withdrew from the meeting.

8 **Emergency Preparedness, Resilience & Response – Update**

The Chair updated the Committee on his meeting with Ms Byrne, Ms Sharpe and Mr McArthur held on 4 January to discuss progress against the Improvement Plan.

Ms Byrne advised that Foundation Commander Training continued with two courses remaining for this year to April. She confirmed that the EPRR department staffing had been enhanced with the Assistant Directors of EPRR due to take up post on 29 January 2024.

Continuing, she advised of engagement with DoH colleagues around HART capacity enhancement and said that, with the appointment to the Assistant Director posts, there would be more capacity to commence work on business cases.

Ms Byrne advised that there had been a positive response to the recruitment exercise for administrative support and it was hoped that a postholder would be in post by mid-March. She added that work had also commenced around the development of a job description and personnel specification for an EPRR Training Officer and it was intended that this work would be completed by mid-February.

Ms Byrne reported that, of the 13 Priority 1 recommendations, two had been completed and 11 were in progress and on track. She alluded to the development of the dashboard which showed progress at a glance and allowed the necessary monitoring to take place to provide assurance.

Ms Byrne added that the Trust had undertaken a recruitment exercise for two additional HART officers.

Mr Bloomfield added that the Trust was only able to recruit to its funded establishment.

The Chair took this opportunity to describe the current HART model in NI and said it was important to highlight the need for discussion with the DoH on this issue.

Mr Sowney acknowledged the position of the Trade Unions (TU) in the context of ASOS around derogation and asked that, given Trade Unions were not in dispute with NIAS, whether there was any potential to discuss derogation around posts in terms of allowing TU representatives to participate in job matching panels given the criticality of the posts and the associated risks carried by the Trust.

Ms Byrne confirmed that Ms Lemon had been engaging closely with TU colleagues.

However, Mr Bloomfield clarified that discussions on derogation were focussed on the day of strike. He advised that he had indicated his intention to discuss EPRR at the Accountability Review meeting with the Permanent Secretary in February.

The Chair expressed his view that he did not believe EPRR was yet in a position whereby it could be considered as normal Committee business and asked for a further briefing meeting to be arranged. He added that an invitation should be extended to the Trust's three new Non-Executive Directors to attend should they wish to do so.

The Chair said it was clear that progress had been made and he commended those involved. However, he said it was important also to recognise the inherent risks involved with the work being taken forward.

The Committee **NOTED** the update.

9 **Strategic Review of Clinical Education – final report (SC25/01/24/05)**

The Chair explained that, while the final report had initially been discussed at the November meeting, he had asked for the report to come back to this meeting so members could have a further opportunity for discussion.

Mr Sinclair explained that the strategic review of clinical education had been commissioned by the Trust's Chief Executive in February

2021 with the aim of modernising and enhancing the development of staff at all levels within the Trust and he highlighted the main findings of the review.

Mr Bloomfield acknowledged that, while there were issues around the content of the course material, the main motivating factor to commission the review focussed heavily on the cultural element. He said that, for many staff coming into the organisation, their first exposure to the Trust was the training team for a number of weeks. Mr Bloomfield emphasised the importance of this being a positive experience and believed it very much set the tone and culture for the workforce. He said that he believed the transformation of the training team led by Mr Sinclair had been positive.

Mr Quinn said that, as a new Non-Executive Director to the Trust, he had found the Strategic Review report to be extremely helpful and interesting. He noted that one of the key issues had been the continuing professionalisation of the organisation and its staff and he believed that the current structure of the education team now reflected that. However, Mr Quinn said he had assumed that clinical supervision would be in place within the Trust and he queried whether clinical supervision performance metrics should be more outcome rather than activity based. He indicated that the overriding point for him was that it was focussed on a particular cohort of staff as opposed to the organisation as a whole.

Continuing, Mr Quinn alluded to a competency framework for the Trust and said that he had had experience of this in a previous organisation. He suggested that a competeny framework would allow the Trust to explore the various capacities such as care, technical or clinical with a view to determining whether the model moving forward could reflect these. Mr Quinn added that proficiencies could also be examined within the remit of a competency framework.

Mr Quinn commended the review and believed it provided a sound background to education within the Trust.

Mr Sinclair explained that the exercise had initially commenced as a review of the Trust's education programme but had subsequently expanded as he had assumed responsibility for the department. He welcomed the opportunity to explore a capacity framework in more detail and believed that, as the Trust was now capturing electronic

data via the REACH tablets, that would allow the Trust to develop a digital dashboard to look at Key Performance Indicators (KPIs) or clinical outcomes and drill down to individual level.

Mr Quinn was of the view that this would be an outcome and suggested that a further outcome related to the staff experience of their education experience.

Mr Sinclair said the Trust had been very fortunate to have the Clinical Support Officer (CSO) tier of staff and explained that, during the pandemic, these officers had been diverted to frontline duties. He explained that Ms Emma Boylan, Consultant Paramedic Clinical Education and Standards, had led a review on CSOs with a view to aligning the guidance, support, policies and education used by the CSOs so they recognise that the Trust has refreshed its education model. He added that the new structure had been aligned to the Association of Ambulance Chief Executives (AACE) and the Allied Health Professions Northern Ireland supervision policies.

Dr Graham described the review as 'impressive' and 'detailed' and was of the view that education was inextricably linked to cultural and organisational change. He commended all involved in the review.

Mr Sowney emphasised the importance of the culture change within the team and said this was clearly evident moving forward. He noted that the paramedics at the Ulster University were now in their third year of study. He said the Trust would be hoping to recruit these students following a recruitment exercise and said they would be instrumental in driving forward change. Mr Sowney said he hoped the work being taken forward by Mr Sinclair and the education team would transcend amongst Station Officers and Clinical Support Officers with a view to creating a supportive environment which would be critical to the Trust's success.

Mr Quinn believed that, from a Continuing Professional Development (CPD) perspective, there was an organic drive which would take place.

Ms Charlton indicated that there was a need to recognise the importance of expertise by experience and believed that when it worked best, it was symbiotic.

Mr Nicholson noted that funding had been prioritised both in terms of the numbers of students and the infrastructure described within the paper. He said that the Trust was exploring the potential to further augment this with driver training mentioned earlier in the meeting.

The Chair congratulated all involved and said that, while the report was presented to the Committee for noting, he would appreciate an update on a biannual basis.

The Committee **NOTED** the Strategic Review of Clinical Education as presented by Mr Sinclair.

10 **Serious Adverse Incidents (SAIs) Update (SC25/01/24/06)**

Ms Charlton drew the Committee's attention to the SAI update and said she wished to highlight a number of points. She said it would be important to note that the context of SAIs in NI would change in the near future and noted that the extant procedure had been in place since 2016. Ms Charlton explained that, following a review by the Regulation and Quality Improvement Authority (RQIA) there was a recognition that the procedure needed to be refreshed. She advised that, in order to progress this, the DoH established a SAI Redesign Group and said that representatives from the Group had met with the Trust Board in October 2023.

Ms Charlton said it was likely the current process would change significantly and acknowledged that there were some elements of the current process which could be improved upon. She said she was of the view that viewing SAIs as figures alone was not helpful and reminded members that behind every complaint, SAI and compliment were patients, families, carers and service users.

Alluding to the paper, Ms Charlton said it was not surprising, given the context of current HSC-wide pressures, the Trust had seen an increase in the number of SAI notifications. She advised that, from August to December 2023, there had been a 22% increase in reporting compared to the same period within the 2022-23 reporting year. She pointed out that the majority of SAIs had been related to a delayed response outwith standard and also took account of the potential impact on the patient.

Ms Charlton explained that the determination as to whether a delayed ambulance response was a direct causal factor to a patient outcome of death was complex and required consideration of a number of factors. She said that, in some cases, NIAS had already identified that the delayed ambulance response had not been a causal factor in the patient's outcome of death. However, she added, several cases were awaiting a determination from the coroner as to whether the delay was a causal factor in the patient's death.

Continuing, Ms Charlton outlined the membership of the Rapid Review Group (RRG) which met on a weekly basis to discuss each incident report recorded on Datix and said that the RRG discussed more incidents than those notified as SAIs. She acknowledged that a challenge for the Trust was the harm not being reported in that it may have been reported to another Trust. She said she, Mr Sinclair and Dr Ruddell were considering other methodology to better understand the pattern of harm.

Ms Charlton drew the Committee's attention to section 4 of the report which highlighted that there had been seven reported incidents in December 2023 within a 10-day period. She indicated that the Trust reported this increase internally through Trust Board and externally through the Early Alert process to the DoH/SPPG. She noted that a similar increase had also been recorded in December 2022.

Ms Charlton highlighted the need to be transparent and said the Trust had invited SPPG colleagues to meet to discuss the increased mortality being seen by the Trust and noted that other Trusts were in a position to report adjusted mortality data. Ms Charlton said that the Trust was exploring themes and benchmarking against other national ambulance services as well as undertaking some sub-group analysis to better understand the specifics in the Trust, for example with whom would learning best be shared.

Ms Charlton highlighted the importance of learning and said the Trust was significant efforts to follow up recommendations and ensure there were robust processes in place to ensure learning was disseminated and steps put in place to ensure improvements. She acknowledged that a significant proportion of SAIs related to delayed response and said the Trust was not seeing an improvement in this area.

Continuing, Ms Charlton said that effective family and staff engagement was important to the Trust as well as the culture of the organisation. She indicated that SAI investigations continued to be viewed on occasions as a punitive process and said that efforts were being made to make it feel different. She said that work was being taken forward through the Professional Standards Lead in Mr Sinclair's Directorate and Clinical Support Officer support around staff reflections. Ms Charlton said it would be important at the Committee to share the human side of the SAIs.

Mr Quinn commended the SAI update report and felt it was very open and transparent. He said he had been interested to note that there would be revisions to the SAI approach and indicated that he would be keen to know the outcomes and how they are continually monitored. He acknowledged that several SAIs were linked to system pressures.

Ms Charlton explained that the report had been drafted by Ms Audrey Murdoch, SAI Lead, and said that there was potential for a number of contributory factors to a delayed response. She cited the example that some learning may focus on how the Trust triaged calls.

Mr Quinn commented on the potential re-traumatisation of the particular family who had not been aware that a delayed response had featured in the incident.

Ms Charlton agreed that it was very challenging and traumatic having to contact a family dealing with a family bereavement to explain that the Trust was not in a position to confirm whether it had contributed to the patient outcome and she acknowledged that this, on occasions, left families having to seek further clarification.

The Committee **NOTED** the report as presented by Ms Charlton.

11 **Service User Feedback, Complaints and Compliments Update (SC25/01/24/07)**

Ms Charlton drew the Committee's attention to the update paper which had been written by Ms McVeigh and Ms Hamilton and reported that, during the period 1 April – 31 December 2023, the Trust had received 175 complaints compared to 166 complaints

during the same period in the previous year. She expressed her surprise at this given the increase in delayed handovers.

Ms Charlton reminded members that they had previously indicated their wish to have sight of the narrative from a complaint and she pointed out that, under the current Complaints Procedure, there was a 20-day timeframe to respond to the complaint.

Continuing, Ms Charlton advised that most complaints fell within EAC and explained that this was not necessarily due to practice but because of the impact of delayed response. She described the current system in place in terms of how the Trust monitored its performance in responding to complaints, ensuring actions were progressed, learning implemented and those complaints yet to be responded to.

She indicated that the average response time for the Trust to a complaint was 35 days. She emphasised that the Trust approach was to ensure a bespoke response to each complaint and said this was signed off by the Chief Executive. Ms Charlton explained that the bespoke response provided a more qualitative response. She advised that the NI Public Services Ombudsman was currently undertaking a review of complaints in the public sector and said that she and Ms McVeigh would participate in the review. Ms Charlton said she hoped that she would be able to influence the timeframe for response to ensure responses were of a more qualitative nature as opposed to the focus being on meeting the timeframe for response.

Ms Charlton reminded members that, upon receipt of compliments, the Trust wrote to the member of staff concerned to share the compliment with them and she pointed out that the Trust received many more compliments than complaints.

Mr Quinn referred to the value of compliments and highlighted the importance of the Trust ensuring bespoke responses to complaints. He believed that this fed back into the organisational culture.

Ms Charlton pointed out that, as NIAS crews conveyed patients to EDs, they often were not aware of the patient outcome. She advised that 0.06% of calls resulted in complaints and indicated that a complaint theme emerging related to patients being asked to walk to the ambulance.

Mr Sowney sought further detail around informal resolution to complaints.

Responding, Ms Charlton explained that, upon receipt of a complaint, the complainant would be asked what they would like to see in terms of outcome. She cited the example of a complaint around crew attitude where the complainant had indicated their wish to receive an apology.

Ms Charlton explained that, when receiving a complaint relating to a member of staff, the Trust had a process in place whereby checks were undertaken to determine if previous complaints had been received regarding that staff member. She advised that, when discussing the complaint at the Rapid Review Group, it was helpful to know whether there was a trend emerging in relation to an individual member of staff and a determination could made on whether the staff member needed additional support with their practice or onward referral to the Trust's Professional Standards Team.

Mr Sowney said he would encourage staff to respond to complaints as early as possible.

Ms Charlton clarified that, if the complaint was linked to clinical practice, an investigation report would be sought. She highlighted the importance of having robust records and engagement with families.

Mr Bloomfield acknowledged that the Trust's performance in terms of responding to complaints within the required 20-day timeframe had not been good. However, he noted that 163 complaints had been closed in nine months which equated to an average of four complaints closed each week and said that, given each complaint required investigation, he commended this outturn. Mr Bloomfield acknowledged that, while it was important for the complainant to receive a response to their complaint quickly, it was more important for that response to respond to the issues raised. He pointed out that very few complainants expressed dissatisfaction with the response received or consulted the NI Public Services Ombudsman on their response.

Ms Charlton said it was her intention to carry out some qualitative work around the experience of those involved in the complaints process. She welcomed the Internal Audit report on complaints which had recently received a satisfactory level of assurance.

Ms Paterson pointed out that Internal Audit had previously given a limited level of assurance in relation to complaints and she commended all involved in the improvements made to the complaints process in terms of framework, governance and structure.

Ms Byrne commented that the thoroughness of the investigation did not lend itself to responding within the 20-day timeframe.

The Committee **NOTED** the update as presented by Ms Charlton.

12 **Independent Ambulance Service Update (SC25/01/24/08)**

Ms Charlton noted the Trust's reliance on independent providers over the last few years and the fact that the service was not regulated in Northern Ireland. She said, as commissioner, there was a recognition that, as part of the Non-Emergency Framework of which all Trusts were clients, there was a need to strengthen governance and assurance around the arrangements provided on behalf of Trusts. Ms Charlton said that, following a cross-Directorate approach within NIAS in terms of health and safety, Infection Prevention Control (IPC), a process was put in place whereby NIAS undertook its own unannounced inspections.

Ms Charlton noted that approximately 58,000 journeys had been undertaken on behalf of NIAS in 2022-23 and said the Trust was striving to reduce its reliance on independent ambulance services. She explained that there had previously been seven independent ambulance service contractors and advised that there were now 16 contractors who had joined the Framework.

Ms Charlton highlighted the increased administrative challenges associated with the increased number of providers on the Framework and said that Ms Paterson intended to liaise with her Director of Planning colleagues with a view to adopting a collective approach to this work.

Ms Charlton referred to the arrangements within NIAS in respect of unannounced inspections, the online audit system and actions plans shared with providers who had been very engaged in the process.

Continuing, Ms Charlton advised that the Trust had engaged with the Regulation Quality and Improvement Authority (RQIA) in the context of the regulatory gap and how this might be considered. She said that the Trust had shared with RQIA colleagues some documentation which had been produced by the Care Quality Commission (CQC) in England. She commended the work which had been done to date and acknowledged that further refinements were needed.

Responding to a question from Mr Quinn, Ms Charlton clarified that the specification and scoping documentation described the level requirements to deliver on the Framework. She indicated that the Trust sought assurance at their quarterly review meetings with providers and asked providers to confirm they met the specification. Ms Charlton acknowledged that the Trust did not have all its own staff trained to the required standards and said that the feedback from independent providers was that having a Framework in place which clearly sets out what was expected of them strengthened their governance and assurance processes. She said she was conscious that some of the providers had small workforces and said NIAS had undertaken to provide Subject Matter Experts to undertake some awareness sessions around complaints, IPC, sharing learning etc.

Mr Quinn noted that the purpose of the regulation through the NI Order was to protect the public and sought clarification on whether there would be a vicarious responsibility on the HSC in the event of an untoward incident, for example, in the area of safeguarding. He said that the level of regulatory risk did not decrease.

Responding, Ms Charlton explained that this issue was currently being explored and said the Trust was attempting to mitigate what it perceived to be the risk. She indicated that, whilst the Trust sought assurances at the quarterly review meetings with providers, the only way it could assure itself from a second level of defence perspective was through unannounced inspections. Ms Charlton said there was now an opportunity to look at this on a regional basis with a view to protecting all organisations.

Mr Bloomfield commended the processes put in place and said that, although these had resulted in improvements, it did not negate the need for regulation.

Mr Nicholson explained that independent ambulance services comprised private and voluntary ambulance services and expenditure was in the region of £7 million per year. He clarified that it did not include taxis and Voluntary Car Services, totalling approximately £600,000 per year.

Responding to a question from Mr Sowney, Ms Charlton explained that there were clauses within the contract which allowed the Trust to stand down a provider until an investigation/review was completed. She added that the Trust could also ask a provider to remove a vehicle from the road if significant risks had been identified.

Mr Sowney asked for confirmation regarding providers using Patient Record Forms (PRFs).

Ms Charlton advised that this was the case and said that the Trust would seek PRFs and crew reflection in any investigations to be undertaken. She added that providers were largely compliant with any requests from the Trust.

Ms Paterson noted the significant expenditure and effort on independent ambulance services and said it would be the Trust's preference to focus on using its own staff to deliver these services.

The Chair thanked Ms Charlton for her update which was **NOTED** by the Committee.

13 **Date of next meeting**

The next Committee meeting will take place on Thursday 25 April 2024 at 9.30am in the Boardroom, NIAS HQ.

14 **Any Other Business**

There were no items of Any Other Business.

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED AT 1.05PM

SIGNED: 

DATE: 25 April 2024

Northern Ireland Ambulance Service
Health and Social Care Trust

'SAFETY' COMMITTEE REPORT TO TRUST BOARD 9/5/24

The Safety, Quality, Patient Experience and Performance Committee met on Thursday 25 April 2024.

	Identification of risk There was discussion regarding the Cat 2 deterioration and cumulative impact of a number of measures to mitigate against staff late finishes including ASOS on the response time particularly at shift handover time.
	Helicopter Medical Emergency Services (HEMS) Annual Report 2023-24 Mr Glenn O'Rorke, NI HEMS Operational Lead, presented the HEMS Annual Report 2023-24 to members, highlighting some general background to the service; the number of missions undertaken since its establishment in 2017 to date; the nature of interventions undertaken; the introduction of Advanced Paramedic Critical Care (APCC); clinical governance arrangements; and strategic and operational objectives for 2024-25.
	Occupational Road Risk & Fleet Safety Policy – Action Plan The Committee noted the action plan which demonstrated a phased trajectory for compliance to the policy's mandate for completion of Driver Competency Review for all staff every five years. Members acknowledged that full compliance would require investment in resources and noted that a business case was in development. It was intended that the Trust would be compliant with prospective legal requirements by the time they come into NI statute which was likely to be 2026-27.
	Emergency Preparedness, Resilience & Response (EPRR) The Committee discussed the current position in relation to EPRR and the Chair updated members on his meeting in March.

Northern Ireland Ambulance Service
Health and Social Care Trust

NIAS Policies

The Committee approved a number of Policies – Controlled Drugs; Medicines; Serious Adverse Incident; Infection Prevention & Control and Complaints.

Members noted that the **Medicines and Controlled Drugs Policies** had been drafted to replace the Policy & Procedures for the Management of Medicines v23. The Policies ensure clear lines of responsibility and accountability for medicines in NIAS.

Members were advised that a review had been undertaken of the extant **SAI Policy** and no substantive changes had been made. The Committee noted that a full review and re-design of the regional SAI framework was underway and the NIAS SAI Policy would be revised to take account of any changes from the regional review.

In relation to the **IPC Policy**, members noted that the Association of Ambulance Chief Executives (AACE) national IPC policy had been amended for NIAS.

Members were advised that the **Complaints Policy and Procedures** had been reviewed and updated to reflect the current complaint handling processes and procedures which were reflective of the regional position whilst ensuring alignment with NIAS' systems and structures.

Infection Prevention & Control: Key Performance Indicators – Environmental & Vehicle Cleanliness update (April 2023-March 2024)

Members noted the update which summarised the performance of the NIAS Environmental & Vehicle Cleanliness (EVC) team in relation to the agreed KPIs for:

- Vehicle Deep Cleaning Completeness
- Vehicle Auditing Compliance
- Vehicle Auditing Completeness
- Station Auditing Compliance
- Station Auditing Completeness

The Committee noted that the Trust had changed from monthly to bi-monthly audits in line with NHS standards and that cleanliness compliance had been maintained.